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LOWERING HEALTH CARE COSTS FOR ALL AMERICANS:

AN EXAMINATION OF THE PRESCRIPTION DRUG SUPPLY CHAIN

WEDNESDAY, FEBRUARY 11, 2026

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The Subcommittee met, pursuant to call, at 10:16 a.m., in Room 2123, Rayburn House Office Building, Hon. H. Morgan Griffith [chairman of the subcommittee] presiding.

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

Also Present: Representatives Allen, Matsui, Mullin, and McClellan.

Staff Present: Christian Calvert, Press Assistant, Press; Jessica Donlon, General Counsel; Kristin Fritsch, Professional Staff Member, Health; Sydney Greene, Director of Finance and Logistics; Jay Gulshen, Chief Counsel, Health; Annabelle Huffman, Clerk, Health; Megan Jackson, Staff Director; Sophie Khanahmadi, Deputy Staff Director; Jonathan Kupperman, Professional Staff Member, Health;

Brayden Lacefield, Special Assistant; Sarah Meier, Counsel and Parliamentarian; Lillian Noland, Staff Assistant; Seth Ricketts, Clerk, Energy and Environment; Jake Riith, Staff Assistant; Chris Sarley, Member Services and Stakeholder Director; Emma Schultheis, Policy Analyst, Health; James Stursberg, Professional Staff Member, Health; Timothy Trimble, Staff Assistant; Matt VanHyfte, Communications Director; Katie West, Press Secretary, Press; Nick Wooldridge, Professional Staff Member, Health; Lydia Abma, Minority Policy Analyst; Jennifer Black, Minority Professional Staff Member; Jacquelyn Bolen, Minority Counsel, Health; Keegan Cardman, Minority Staff Assistant; Ava Digre, Minority Intern; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Tiffany Guarascio, Minority Staff Director; Jackson Hall, Minority Intern; Perry Hamilton, Minority Deputy Director of Member Services and Outreach; Brent Langellier, Minority Health Fellow; Una Lee, Minority Chief Counsel, Health; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; Hannah Treger, Minority Staff Assistant; Laurel Uhomba, Minority Health Fellow; and Kyle Wolf, Minority Press Intern.

Mr. Griffith. The subcommittee will come to order. The chair recognizes himself for a 5-minute opening statement.

First, I want to recognize the bipartisan bill that we were able to pass last week, that included many important healthcare provisions and lowered healthcare costs for all Americans.

Today we will discuss healthcare costs and patient-access challenges by examining affordability across the entire pharmaceutical supply chain.

I am proud of this subcommittee's work, but there is still more to be done, which is why I am here to continue building on our affordability series with today's hearing that comes after we heard from insurance executives last month. We now will hear from stakeholders who are a part of the complex pharmaceutical drug supply chain.

To regular people, this system may seem simple. A disease is researched, and a treatment is developed. Then that treatment is manufactured and distributed to a hospital, pharmacy, or other healthcare entity before it is dispensed to the patient.

However, there are many more layers that are involved in this process that affect how a drug gets to a patient and how the drug is priced.

One of the most frustrating aspects of the supply chain is that it operates as if in a black box. Luckily, we have witnesses here to provide their perspectives and shine a light on the process.

Do each of these entities in front of us today play a role in getting the drug to a patient? Yes. Are there too many cooks in the kitchen at times? Probably so.

Today is a great opportunity for Congress to get a glimpse and see what is happening and look for ways to help make prescription drugs more affordable.

In 2017, this same subcommittee held a similar hearing to the one we are doing today, but a lot has changed since then. I am glad we are reexamining what we learned from that hearing to continue working towards what we all want: lowering costs for patients while ensuring that

America remains a leader in pharmaceutical innovation.

We have PhRMA and BIO in front of us who can speak to the intricacies that go into research, developing, and pricing a drug on the market.

We will also get the perspective of generic drugs from the Association for Accessible Medicines, who can speak on the issues in that arena.

We also have the Pharmaceutical Care Management Association here as the trade association that represents pharmaceutical benefit managers, commonly known as the PBMs.

What we heard in our hearing last month is that insurance companies own many of these PBMs. In fact, the largest three PBMs are owned by insurance companies, and they control over 80 percent of the market. How they manage these benefits is a mystery at times and can lead, in some cases, to higher prices.

However, just last week, led by Representative Buddy Carter from Georgia, Congress passed, and the President signed into law, the biggest PBM reform package in history. These bills will bring more transparency into this system, lower costs, and allow for more access to medicines.

The Healthcare Supply Chain Association is here on behalf of Group Purchasing Organizations, or GPOs, which act as intermediaries between manufacturers and providers.

In front of us is also the healthcare distribution alliance who is involved in the distribution of prescription drugs along the supply chain.

I am looking forward to hearing from the National Community Pharmacists Association, who is also with us today, since they represent the community pharmacists that so many of us use. These community pharmacies serve a critical role in bringing care to patients, especially in rural areas.

Yet many have had to sadly close their doors in recent years due to some of the factors that we will discuss today.

The ERISA Industry Committee is also here to discuss their point of view for employers when

it comes to high costs as well as decisions they make based on those costs.

Each of these different entities play a unique role in how a drug finally gets to a patient. In this meeting, we will hear from these witnesses on how to navigate this complex web on behalf of the American people.

I look forward to the discussion, and with that, as I said, I look forward to it, I yield back, and now recognize the ranking member of the subcommittee, Ms. DeGette, for her 5-minute opening statement.

[The prepared statement of Mr. Griffith follows:]

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

Ms. DeGette. Thank you so much, Mr. Chairman.

This panel is going to testify today about how complex the drug supply chain and drug pricing have become, and it is true. We have a convoluted system that does too much to reward pricing games and too little to reward effectiveness and true innovation.

And the high prices are systemic. That is why this diverse panel will, I hope, provide some information that may begin to help us untangle this issue.

I am proud of the work that the House Democrats have done to begin to make drugs more affordable. In the Inflation Reduction Act, Democrats made it so that drug companies could not raise their prices faster than inflation. Gone are the days of double-digital price increases on life-saving drugs year after year.

Democrats also fought for Medicare drug price negotiations, and these negotiations have already lowered the costs of the 10 most expensive drugs in Medicare, starting this year.

For example, 4 million seniors take Eliquis for blood clots, and, thanks to the IRA, Medicare secured a 56 percent discount off list price.

Next up are certain popular GLP-1 drugs, which will be discounted 71 percent in 2027. Other high-cost therapies will be discounted as much as 85 percent, all thanks to congressional Democrats. And we are just getting started.

But meanwhile the biggest drug companies are making back-room deals with the Trump administration in response to extortionate and, frankly, illegal tariff threats.

Unlike the Inflation Reduction Act, which created clear and predictable mechanisms for negotiating drug prices and capping out-of-pocket costs, the public has no idea what back-room agreements are between drugmakers and the White House.

I think that we would all be very interested in learning more about the President's deals with the drug companies. Frankly, if they are worth the paper they are written on, they need to be

made public.

But we are here today to talk about affordability. So, if the majority were being honest with itself about affordability, we would do two things right away, and it would help.

Number one, bring back the ACA enhanced premium tax credits. That would be the easiest way to lower healthcare costs for millions of Americans on a short-term basis, including Ethan Allen, who -- or I am sorry -- Ellen Allen, who this committee heard from in our last hearing.

Number two, here it comes, repeal H.R. 1, what I call the Republicans "big, bad bill." H.R. 1 included a provision to exclude certain high-cost drugs from Medicare drug price negotiations, which will cost the American public $8.8 billion.

That means persistently high prices for the American people of drugs that have been on the market for years.

This bill also set up 15 million people to lose their health insurance. Now, obviously that will make healthcare unaffordable for those 15 million people, but it also impacts everybody else.

Why? Because just because someone is uninsured doesn't mean they don't get sick. Uninsured people end up going to the emergency rooms, which is one of the most -- probably the most expensive settings of care.

And, when they can't pay, since the majority took away their health insurance, the costs increase for everybody and are passed down to people with private insurance.

And also H.R. 1 will add $443 billion to hospitals' uncompensated care costs through 2034. That is a huge cost that is going to be borne out by people in every single one of our congressional districts.

I think we can all agree that it is cheaper to prevent and treat early rather than treat late.

So why did we pass legislation that doctors, hospitals, policy experts, and most importantly, patients, all agree is going to make healthcare more expensive?

Meanwhile, the majority has turned a blind eye to grant cancellations, political interference,

and instability at the agencies that are the backbone of America's biomedicine ecosystem, which has become the envy of this world.

As we talk about the pharmaceutical supply chain today, let's remember where every treatment and cure starts: as a research project, seeking to understand biology.

GLP-1 drugs that I talked about earlier started out that way. They wouldn't have been discovered without our basic research infrastructure.

They came out of research -- it might sound ridiculous -- a study of the Gila monster venom. That is what helps lead to drugs that cure millions of people. We need to embrace that type of research. We can't allow it to be stifled.

There is a lot to unpack here, and I am looking forward to the hearing. I yield back.

[The prepared statement of Ms. DeGette follows:]

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

Mr. Griffith. The gentlelady yields back.

I now recognize the chair of the full committee, Chairman Guthrie of Kentucky, for his 5-minute opening statement.

The Chair. Thank you, Chairman Griffith, for holding this hearing.

And, to Ranking Member DeGette, this is similar to a hearing we held when you chaired O&I and I was -- a supply chain hearing. So hopefully we will get some of the good answers that we got then today and hopefully some improvements.

But we are here to talk about the U.S. prescription drug supply chain. From the discovery of a molecule to the dispensing of a drug, the prescription drug supply chain is a complicated web of financial and logistical transactions.

In 2017, the Committee held a very similar drug supply chain hearing, which led to Congress passing, and President Trump signing into law, the most consequential and comprehensive PBM reform legislation in history just last week.

Those policies will improve prescription drug affordability for all Americans.

Historic PBM reform is just the beginning, and more needs to be done throughout the drug supply chain to improve affordability for all Americans.

Since our hearing in 2017, the prescription drug supply chain has evolved in many ways. We have seen significant vertical integration, not just among the largest PBMs, but also on part of the wholesalers, who now own and operate provider groups, pharmacy services, administrative organizations, GPOs, pharmacies, and white-label manufacturers.

We have also seen shifts in pharmaceutical contracting and revenue generation, from PBMs accruing a major portion of their profits in fees charged to payers and manufacturers, to payers working with broker consultants and often demanding rebate guarantees as part of their pharmaceutical benefit management contracts, which may impact behavior and incentives up and

down the supply chain.

We have also seen major changes in Federal policy. The Democrats' Inflation Reduction Act has destabilized the market – Part D marketplace to a degree that the Biden administration had to divert billions of taxpayer dollars just to temporarily keep the market afloat.

On the other hand, just last week, Trump -- President Trump launched Trump RX, a new platform designed to help patients find the lowest possible, direct-to-consumer, cash price for some of the most common medicines Americans shop for outside of their insurance.

I look forward to examining all of these issues across each of the prescription supply chain and learning more about what more we can do to make the healthcare system more affordable for patients across the country.

Thank you for all witnesses for being here. We look forward to a discussion and hopefully getting to some answers in the next few hours. And I thank you for being here, and I will yield back.

[The prepared statement of The Chair follows:]

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Mr. Griffith. The gentleman yields back.

I now recognize the ranking member of the full committee, the gentleman from New Jersey, Mr. Pallone, for his 5 minutes for an opening statement.

Mr. Pallone. Thank you, Chairman Griffith. Once again, the Health Subcommittee is meeting today to examine healthcare affordability while Republicans sit by and refuse to address one key way to lower healthcare costs, and that is extending the Affordable Care Act, its enhanced premium tax credit, to lower monthly health insurance premiums for millions of Americans.

The truth is Republicans are holding this hearing because they have no real plan to lower health costs or improve quality of care and have spent the last year creating a health crisis, taking healthcare coverage away from 15 million people, raising costs for millions more, and slashing a trillion dollars in health funding in their "big, ugly bill."

Their signature bill will not only result in massive benefit cuts, higher prices for patients, and hospitals closing their doors, but it will also increase drug prices for seniors. Hidden in the fine print of the "big, ugly bill" was a new loophole to allow massive blockbuster drugs, such as Keytruda, to avoid Medicare price negotiations.

This was a $9 billion Republican handout to the pharmaceutical industry tucked away in the "big, ugly bill." Make no mistake, Republicans knew what they were doing when they prioritized Big Pharma's profits over patients -- patients who will be forced to pay higher prices for life-saving drugs for years to come.

And, instead of working together to lower costs, it appears that Republicans' goal for today's hearing is to allow different players in the pharmaceutical drug supply chain to point blame at each other, while this committee does nothing to actually help lower healthcare costs for everyday Americans.

It is also worth noting that Republicans denied Democrats' request to include a witness who

could represent a patient's perspective, ignoring the 1 in 7 Americans who have been forced to cut their pills in half or skip doses of their medication due to the costs in the last year. And that is a shame certainly.

Republicans have also stood by and allowed the Trump administration to undermine our Nation's health agencies charged with protecting Americans. Time and again, Republicans have done nothing to stop Trump and Robert F. Kennedy, Jr.'s attacks on life-saving medical research and innovation, putting new cures and treatments out of reach for millions of people.

They have sat back and watched as billions of dollars in scientific research funding has been cut, frozen, or terminated, and they have allowed RFK Jr.'s quack science to run rampant, decimating people's trust in vaccines.

So now we are facing the worst measles epidemic in three decades on President Trump's watch. This committee should be doing important bipartisan oversight of the growing measles crisis and the Federal Government's response.

But shockingly the new head of CDC says that rising cases are, quote, just the cost of doing business. Kids getting sick from preventable diseases, hospitalized, and even dying is just, quote, the cost of doing business under the Trump administration.

Undoubtedly, these devastating actions will negatively impact healthcare access, affordability, and our Nation's public health for decades to come long after the Trump administration has gone.

So, if you want to address prescription drug affordability, we should build on the successes of the Inflation Reduction Act. It took Democrats more than 20 years to finally beat back Big Pharma and Republicans to empower Medicare to negotiate lower prices for America's seniors.

As of January 1st, seniors have access to these lower negotiated prices. This year alone, seniors are expected to save about $1.5 billion in out-of-pocket expenses and not one Republican supported this law.

And, if Republicans are really interested in making prescription drugs more affordable, they

would support my legislation to extend negotiated prices to everyone with private healthcare coverage.

The Lowering Drug Costs for American Families Act also caps out-of-pocket costs for prescription drugs for more Americans and further prevents unfair price hikes for drugs already on the market.

And these are real solutions and stand in sharp contrast to the secret deals that the Trump administration is making with the pharmaceutical industry that do nothing to lower costs.

Democrats stand ready to continue our efforts to lower drug prices and deliver savings to the American people, and I would urge my Republican colleagues to join us. With that, Mr. Chairman, I yield back. Thank you.

[The prepared statement of Mr. Pallone follows:]

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Mr. Griffith. The gentleman yields back. We now conclude with member opening statements. The chair would like to remind members that, pursuant to committee rules, all Members' opening statements will be made a part of the record.

We want to thank our witnesses for taking their time to testify before our subcommittee today. Although it is not the practice of this subcommittee to swear in witnesses, I would remind our witnesses that knowingly and willfully making material false statements to the legislative branch is against the law under Title 18, section 1001, of the United States Code.

You will have an opportunity to give an opening statement followed by questions from members. Our witnesses today are Lori Reilly, chief operating officer with PhRMA; John Crowley, president and CEO of Biotechnic Innovation Organization; John Murphy, president and CEO, Association for Accessible Medicines; David Marin, president and CEO, Pharmaceutical Care Management Association; "Chip" Davis, Jr., president and CEO of Healthcare Distribution Alliance; Angie Boliver, president and CEO of Healthcare Supply Chain Association; James Gelfand, president and CEO of The ERISA Industry Committee; James Hoey, chief executive officer, National Community Pharmacists Association; and Rachel Sachs, professor of law, Washington University in St. Louis.

Per the committee custom, each witness will have the opportunity -- and I underscore that today -- for a 5-minute opening statement, followed by a round of questions from members. You may notice that several of us in our opening statements did not use our whole 5 minutes.

So, if you have already said what you need to say, because we have nine witnesses, which is the most I think I have ever seen since I have been on the committee, but it was necessary to try to get the full picture -- so, if you don't use your whole 5 minutes, nobody is going to be upset with you. Just saying.

The light on the timer in front of you will turn from green to yellow when you have 1 minute left. I now recognize Ms. Lori Reilly for 5 minutes to give her opening statement.

Are you live?

Ms. Reilly. It doesn't seem to work.

Mr. Griffith. It is hard to see the light. There you go.

No, we had you for a second.

Ms. Reilly. Okay, now?

Mr. Griffith. There you go.

STATEMENTS OF LORI M. REILLY, ESQ. CHIEF OPERATING OFFICER, PHRMA; JOHN F. CROWLEY, PRESIDENT AND CEO, BIOTECHNOLOGY INNOVATION ORGANIZATION; JOHN MURPHY, PRESIDENT AND CEO, ASSOCIATION FOR ACCESSIBLE MEDICINES; DAVID MARIN, PRESIDENT AND CEO, PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION; ANGIE BOLIVER, PRESIDENT AND CEO, HEALTHCARE SUPPLY CHAIN ASSOCIATION; CHESTER "CHIP" DAVIS, JR. PRESIDENT AND CEO, HEALTHCARE DISTRIBUTION ALLIANCE; JAMES GELFAND, PRESIDENT AND CEO, THE ERISA INDUSTRY COMMITTEE; B. DOUGLAS HOEY, CHIEF EXECUTIVE OFFICER, NATIONAL COMMUNITY PHARMACISTS ASSOCIATION; AND RACHEL E. SACHS, PROFESSOR OF LAW, WASHINGTON UNIVERSITY IN ST. LOUIS.

STATEMENT OF LORI M. REILLY, ESQ.

Ms. Reilly. Thank you. Chairman Griffith, Ranking Member DeGette, and members of the subcommittee, thank you for having me here today. I want to highlight three important points for my written testimony.

First, the U.S. has a unique ecosystem that provides patients and workers many benefits. We lead the world in medical discovery in the United States. And, as a result, American patients get access to our medicines first before anyone else in the world.

While other countries wait often 3 years on average to get medicines, patients in the U.S. get them months after FDA approval.

Over the last 10 years, our members invested $850 billion in research and development, supporting our economy and over 5 million jobs in the United States.

I would say one of the most under-appreciated aspects of our system in the United States is our unique intellectual property system that balances innovation and lower costs.

Just think about the last time you were in a hospital or a doctor's office. It probably looked

the same as it did 10 years ago. But our industry looks radically different today than it did 10 years ago, because we brought over 500 new medicines to market in that time.

The share of healthcare spending devoted to prescription drugs remains at 14 percent today, the same as it was 10 years ago, and the same as it is projected to be in the next 10 years. And the reason for that is that we have this unique system that balances innovation with lower costs.

A first-in-class medicine that gets approved today for market can expect to face competition from another branded medicine in less than 2 years. That same medicine will face generic competition in average in 13 years.

In the U.S. today, 90 percent of all prescriptions written are for generic medicines at an average cost of under $7 per prescription. We use more generic medicines than anywhere else in the world, and they happen to be cheaper here too.

As a result of our high use of generic medicines, our Medicare and Medicaid programs pay 18 percent less for all medicines relative to our OECD peers.

However, the unique challenges we face in our system are in part because we have a convoluted supply chain that exists in our system that does not lower costs oftentimes for patients and actually puts hurdles in the way of patients being able to access their medicine.

America is the only country in the world where half of every dollar goes to someone other than the company that invented or manufactured the medicine.

PBMs get $1 out of every $4 of a brand medicine that is sold today. That is $170 billion a year going to a Fortune 10 company that did not invent the medicine.

I commend lawmakers for taking the important first steps that you did in passing PBM reform, but more remains to be done. We need to address the perverse incentives in the system that are caused by vertical integration and consolidation.

Today, just three companies control 80 percent of all prescriptions, and today they are steadily acquiring pharmacies and providers and paying those entities more than the ones they are

not affiliated with.

As a result, independent pharmacies and providers are going out of business.

It is hard to know the true size of this problem because candidly, they have invented yet another way to stay out of sight. They have added another level of complexity by offshore GPOs that are out of sight of employers and taxpayers and are driving up costs and making it harder for patients to get the medicines they need.

The burden of this system unfortunately falls squarely on patients today. Over 1,400 medicines are excluded from the top three PBM formularies.

A patient in Medicare Part D who is prescribed a new brand medicine can expect to have that medicine's coverage denied half of the time. In the case of the commercial insured patient, they can expect to have it denied 70 percent of the time.

I would be remiss to not mention the 340-B program, which is the fastest growing Federal drug program that exists. Oftentimes I hear this program being described as a complicated one, but it is really not all that complicated.

Half of all hospitals in this country get access to the 340-B program which entitles them to buy medicines at a significant discount, on average, 57 percent. They are then allowed to mark up those medicines as high as a thousand percent, or more, and charge taxpayers and employers whatever they want for those medicines.

This program has grown considerably and is now an $81 billion profit center for PBMs, private equity, and not-for-profit hospitals, and I would encourage this committee to look further into this program.

We have challenges that need to be solved in our system, but I would ask the committee to do so in a way that doesn't sacrifice medical innovation. Today China is nipping at our heels. They want to be the next center for medical innovation and progress in our country.

Today phase 1 trials are done 50 percent faster and 40 percent cheaper in China. They are

30 percent of global clinical trial spots, and in the next few years, could surpass the U.S. if we do not do things to ensure that we remain the global leader in medical innovation.

The way to win this race, though, is to ensure that the U.S. is the best place to invest in and manufacture new medicines and to protect what is working in the system and reform the parts of the system that are adding costs and not adding value to patients, and to reject items, like price controls, which will harm innovation and put us further behind. Thank you very much.

[The prepared statement of Ms. Reilly follows:]

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Mr. Griffith. I thank the gentlelady and now recognize Mr. Crowley for his time.

STATEMENT OF JOHN F. CROWLEY

Mr. Crowley. Great. Thank you, Chairman Griffith, Ranking Member DeGette, distinguished members of the subcommittee, and thanks for the opportunity to appear on behalf of the Biotechnology Innovation Organization.

BIO is our Nation's leading advocacy organization for biotechnologies companies. We represent more than 1,000 biotech companies in America in all 50 States. These are the men and women whose expertise and entrepreneurship are at the heart and soul of creating newer and better medicines -- the modern miracles that extend, enhance, and save human life.

Developing cutting-edge biotechnologies only a generation ago seemed impossible. My family and I know what it was like back then. For our family, more than 25 years ago, our two youngest children, Megan and Patrick, were diagnosed with a rare form of muscular dystrophy known as Pompe disease.

That is what led me, more than a quarter of a century ago to become a biotech entrepreneur.

The medicine that we eventually did develop was borne from the genius of American scientists, businesspeople, and it was approved here in the United States first by the U.S. FDA. It gave my children and many others a chance at life.

Groundbreaking medical innovation can save lives, but more and more, we keep getting in our own way with a system that is inefficient, overly complex, and fraught with middlemen.

It is complicated at times also by government policies that harm, rather than advance, newer and better medicines for the American people.

At the heart of America's innovation ecosystem are our small and midsize biotech companies,

which together originate more than 70 percent of all new medicines and which continue to lead the world.

But maintaining and advancing America's lead in biotech is not a foregone conclusion. We must continue to find ways to reform and modernize the U.S. FDA, to reduce the complexity and redundancies of our clinical trial system, to embrace actions that will reduce costs and improve both affordability and the health of all Americans.

And we must remember that the United States already is the most favorite Nation when it comes to developing groundbreaking new medicines that transform the standard of care for patients.

The codification of MFN policies risks importing socialized medicine and harming much of what makes American biotech innovation exceptional, while failing to address the real drivers of the affordability crisis in our country.

The most sensible and patient-centered approach to lowering healthcare costs starts with simplifying our system. The United States is the only country in the world where 50 percent of every dollar spent on medicines goes to middlemen, mostly toward the PBMs.

While the hospital systems regularly mark up the price of medicines, health insurers limit patient access to medicine.

Today it is as if a physician writes a prescription for their patient, and it is simply a recommendation to an insurance company. More and more the insurance company model is to delay and to deny.

For too many Americans, though, delaying and denial equals suffering and death.

Something must be done. Originating out of this committee more than a decade ago was the legislation that became law known as the 21st Century Cures Act. We believe that now is the time for a 21st century access and affordability.

Making great medicines alone is simply not enough. We need to ensure that every American has access to these biotech miracles, and that no one -- no one -- ever goes a day without

the medicines they need.

The time is now. We are no longer living on the cusp of a golden age of medicine. We are living in the golden age of medicine. We have now the biotechnologies and the abilities to alleviate an enormous amount of human suffering.

Let's, together, work to simplify the system and allow American biotechnology innovation to deliver medical miracles to the world. Thank you.

[The prepared statement of Mr. Crowley follows:]

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Mr. Griffith. The gentleman yields back.

I now recognize Mr. Murphy -- Mr. John Murphy for his 5-minute opening.

STATEMENT OF JOHN MURPHY

Mr. Murphy. Chairman Griffith, Ranking Member DeGette, members of the subcommittee, thank you for the opportunity to testify today about this critical issue.

The Association for Accessible Medicines represents the generic and biosimilars industry that Americans rely on every day. Generics and biosimilars are the single largest driver of prescription drug affordability in the United States.

In 2024 alone, they generated $467 billion in savings for patients in the healthcare system. Those savings flow across Medicare, Medicaid, private insurance, and directly to patients managing chronic and complex conditions.

Yet despite that success, the full affordability potential of generics and biosimilars is being suppressed by market distortions and outdated policies.

Congress has a real opportunity to unlock even greater savings simply by allowing these markets to function as intended.

For instance, generic medicines, while accounting for almost 90 percent of prescriptions filled in the United States, unfortunately only represent 12 percent of total drug spending. This is down from 27 percent just a decade ago.

In fact, generics right now are the only sector of the prescription drug market where total spending has declined over the past decade, even as volume has increased.

Meanwhile, overall drug spending continues to rise because costs are increasingly concentrated in a small number of high-priced brand and specialty medicines.

In 2023, spending on just two brand medicines -- Ozempic and Humira -- exceeded total spending of more than 1,000 generic medicines combined in the United States. That imbalance should concern anyone focused on affordability.

For manufacturers, this relentless price compression has real consequences. Generic drugs launch at lower prices than ever before and continue falling well below historic norms.

At the same time, fixed costs, regulatory burdens, and supply chain risks continue to rise. When margins collapse, manufacturers exit, redundancy disappears, and shortages become likely.

Biosimilars face an additional challenge. Despite clear evidence of safety and effectiveness, the United States continues to lag Europe and Canada in biosimilar uptake and patient access.

In too many cases, patients cannot reach lower cost alternatives, for many reasons -- brand patent games, formulary decisions, rebate structures, and reimbursement policies that favor high-priced medicines over lower-priced biosimilars.

This is not a failure of science or manufacturing. It is a failure of policy.

There are four areas where Congress can act -- first, with regulatory barriers. FDA should be clearly empowered by Congress to streamline outdated requirements that delay competition, including eliminating unnecessary clinical studies for biosimilars and aligning U.S. policy with global standards by deeming biosimilars interchangeable upon approval.

Second, patent abuse. Brand manufacturers increasingly deploy patent thickets to block competition long after true innovation has been rewarded. Congress can curb these tactics by strengthening patent review processes, streamlining patent litigation, and protecting legitimate tools, like skinny labeling, that were built into the congressional legislation establishing these markets years ago.

Third, we have misaligned incentives in the Medicare, Medicaid, and PBM practices. Today higher-priced drugs often win preferred placement because rebates and fees reward list price, not the lowest net cost to plans or to patients. That hurts patients and taxpayers and keeps lower cost

generics and biosimilars off of pharmacy shelves.

And, fourth, supply chain sustainability. Inadequate reimbursement, especially in Medicare Part B and Medicaid, is pushing some generics towards chronic shortages.

Without predictable and accurate payment, manufacturers cannot sustain reliable supply.

If these issues go unaddressed, the result will be fewer competitors, more shortages, higher costs, and reduced access for patients.

Generic and biosimilar medicines are not a theoretical solution. They are already doing the work. Protecting the future requires deliberate policy choices that restore competition, reward affordability, and keep patients first.

Thank you. I look forward to your questions.

[The prepared statement of Mr. Murphy follows:]

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

Mr. Griffith. Thank you. The gentleman yields back.

I now recognize Mr. Marin for his 5 minutes.

STATEMENT OF DAVID MARIN

Mr. Marin. Good morning, Chairman Griffith, Ranking Member DeGette, members of the subcommittee. Thank you for having me here today.

My name is Dave Marin. I am president and CEO of PCMA. It is a role I have been in for all of 3 weeks now. I appreciate you wasting no time having me come in.

I actually am pleased to be here today to have the chance to talk about the critical role PBMs play to make healthcare more affordable, accessible, and safe, and the ways our companies are evolving to respond to the market, to patients, and to policymakers.

I am also pleased that we have the full drug supply chain here today. Each of us has a job to do getting people the medications they need to ensure affordability.

Before going any further, though, Mr. Chairman, I would like to acknowledge that as an association, we have failed you. We have not done a good-enough job articulating PBMs' value to you. We have not been the partner you need. We are going to change that.

But I also have to say, in just a few short days, it has become clear to me, we have allowed other sectors, including some here today, to misrepresent us, often wildly so, and cloud the facts for policymakers and the public.

Some have spent millions and millions of dollars to convince you that the ones who make drugs cheaper -- PBMs -- are the problem. It is a remarkable achievement really, and I tip my cap to my pharma friends, a master class in persuasion that should be taught in lobbyist school.

But there is also, pardon me, Mr. Chairman, a lot of bunk out there, and it is my job to clear

that up.

My commitment to you today is that we will work with this committee to answer your questions, be a better partner, and help advance solutions that will make it easier and more affordable for your constituents to get the medications they need.

Our companies are already doing so. They have increased transparency, increased reimbursement for independent pharmacies, created new models that align incentives and maximize savings for employers and for patients.

Their evolution continues. The PBM industry today is not the one of 10, 5, or even a couple years ago.

Remember, no one has to hire a PBM. They do so because medicines can be extraordinarily expensive, often breathtakingly so, and they need someone to help hold down those costs.

PBMs do a lot. They use their leverage to drive discounts. They administer the drug benefit for patients. They promote patient safety, guarding against potentially harmful drug interactions, and supporting drug adherence. This stuff is hard.

Here are some facts. Prescription drugs are more affordable for patients because of the work PBMs do. We saved more than $300 billion for the 289 million people we served last year.

Generic drugs are more often filled because of the work PBMs do. Taxpayers save money because of the work PBMs do. Independent pharmacies are reimbursed at a higher rate than the big chain ones. Employers have transparency because we are accountable to them.

Yes, drug prices are still too high. Without PBMs, they would be much, much higher.

Congress just approved far-reaching legislation that impacts our industry, transparency requirements, full rebate pass-through, delinking. It won't surprise the committee that we believe these mandates were both unnecessary and potentially harmful to our shared goal of affordability.

But now we hope to move forward with you, to focus on the issues at the core of our affordability challenges, to demonstrate the value of the improvements PBMs are already making,

and, yes, to address the root causes of high drug prices.

Not only do drug companies enjoy extraordinary government protections from competition, they then game the system over and over and over again, to further prevent competition and block generics from reaching patients.

And the massive drug wholesalers and PSAOs, really one and the same, they wield enormous power over the prices of generic drugs and what pharmacies pay for medicines, with essentially no oversight.

We hope the committee can broaden its inquiry into these and other parts of the supply chain. Competition has to be at the core of our affordability mission. When there is competition, prices come down, and the promise of pharmaceutical innovation can actually be enjoyed by the people who need it.

Mr. Chairman, thank you for having me. I look forward to working with the committee.

[The prepared statement of Mr. Marin follows:]

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

Mr. Griffith. Thank you so much.

I now recognize Mr. Davis for his 5-minute opening.

STATEMENT OF CHESTER "CHIP" DAVIS, JR.

Mr. Davis. Chairman Griffith, Ranking Member DeGette, distinguished members of the subcommittee --

Mr. Griffith. And if you could pull the mic a little closer to you.

Mr. Davis. Is that better now?

Mr. Griffith. Yes.

Mr. Davis. Okay. Chairman Griffith, Ranking Member DeGette, and distinguished members of the subcommittee, good morning. My name is Chip Davis. I am the president and CEO of the Healthcare Distribution Alliance, and on behalf of our members, I want to thank you for the opportunity to share the pharmaceutical distribution sector's perspective in this important hearing.

Distributors are the backbone of the pharmaceutical supply chain, handling approximately 96 percent of all medicines that move through the supply chain and are dispensed in the United States.

Our members are in a very unique position. They work each day to connect approximately 1,400 manufacturers with over 450,000 distinct sites of care delivery, making distributors unique and unlike anyone else in this supply chain.

Our members use their logistics expertise to take physical possession of medicine, to take legal title of medicine, and the liability and security risks that come with it, to deliver 10 and a half million products daily across the United States.

They do this all while maintaining the lowest margins within the supply chain.

All of our members, 36 distributors total, are headquartered here in the United States, and all operate here in the United States. And they support more than 300,000 American jobs and contribute almost $32 billion annually to the U.S. economy.

Distributors, while arguably not as visible at times as front-end manufacturers or frontline providers, are critical to our Nation's healthcare system. Their operating model creates efficiencies by streamlining the functions to move product from manufacturer to providers and ultimately and, most importantly, to the patients.

As this committee seeks to further examine the prescription drug supply chain, it is important to note that while distributors do not decide what medicine a physician prescribes, or a pharmacist dispenses, or what a manufacturer charges list price, known as WAC, or what a patient pays for at the pharmacy counter, our members do work diligently every day to ensure that the right medicine at the right dose is available at the point of care at the right time.

Over time distributors have eliminated the need for manufacturers to build and maintain their own internal capacity for distribution to each of those hundreds of thousands of points of care I referenced on a daily basis.

In fact, the efficiencies that distributors bring to the supply chain and healthcare system save approximately $78 billion annually here in the United States. Our members take very seriously their role to maintain a safe, secure, and highly regulated pharmaceutical supply chain.

This end-to-end system, again partnering upstream and downstream, is designed with patient protections in mind and to avoid the risk of counterfeit, stolen, or contaminated drugs.

For many years, there has been a policy focus on increasing affordability for patients. Congress has enacted numerous proposals intended to lower patient costs, but to the credit of this committee, there is still more work to be done.

As we engage here today, we agree that there is an opportunity for reform and improvements designed to benefit patients and ease provider burdens, while simultaneously

hopefully not having the unintentional impact of disrupting the efficiency, the security, and the reliability of medicines as they move their way through the pharmaceutical supply chain to the point of care and, again, most importantly, to the patient.

In the end, the healthcare distribution system is designed to deliver products to the providers that rely on them so that they can, importantly, treat their patients.

HDA and the distribution sector stand ready to continue to meet this challenge, recognizing the importance to millions of Americans who depend on medicines for their well-being every day.

Thank you for your time. I look forward to your questions.

[The prepared statement of Mr. Davis follows:]

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

Mr. Griffith. Thank you very much.

I now recognize Ms. Boliver.

STATEMENT OF ANGIE BOLIVER

Ms. Boliver. All right. Is that on?

Mr. Griffith. You are on.

Ms. Boliver. Okay. Excellent.

Chairman Guthrie, Ranking Member Pallone, Chairman Griffith, Ranking Member DeGette, and distinguished members of the subcommittee, thank you for the opportunity to discuss the important role of traditional healthcare group purchasing organizations in lowering costs in the pharmaceutical supply chain.

The Healthcare Supply Chain Association and our member GPOs appreciate your focus on improving healthcare affordability, and we look forward to continuing to work with Congress and all stakeholders on this important issue.

Today I would like to highlight two points -- first, the significant cost savings that traditional healthcare GPOs deliver for providers and patients, and second, the distinct role that GPOs play compared to other entities in the healthcare supply chain.

The traditional healthcare GPOs that I represent serve as the sourcing and contracting partners to American hospitals, long-term care facilities, surgery centers, clinics, and other healthcare providers.

Initially formed the early 1900s, traditional healthcare GPOs are a kind of co-op, combining purchasing volume on behalf of providers, driving competition amongst suppliers, and reducing healthcare costs.

GPOs help secure access to medical products for their provider members under fair and affordable terms, driving billions in savings for patients, providers, Medicare, Medicaid, and taxpayers.

One analysis found that GPOs deliver annual provider savings of 12 to 18 percent of their total supply purchases. GPO services enable providers and physicians to focus on their core mission, providing first-class patient care.

GPOs contract for a broad range of healthcare products and services including drugs, but also medical devices, surgical equipment, cybersecurity, hospital food, and PPE.

Hospitals and other providers also rely on GPOs for services well beyond supply contracting and procurement, including supply chain analytics, emergency preparedness and disaster response, risk management and compliance, among others.

GPOs are particularly important for small and rural providers. These facilities face persistent financial pressures that threaten their ability to stay open. Small and rural providers often lack purchasing power, transactional experience, and personnel.

To counter this, GPOs help them access affordable prices and favorable terms on essential supplies, on par with their larger healthcare counterparts.

Traditional healthcare GPO contracts are completely voluntary for both providers and suppliers. No provider is required to join a GPO. Providers have flexibility to purchase outside of the GPO contract, and most providers belong to multiple GPOs.

Similarly, no supplier is required to contract with a GPO, and many choose to sell their products directly to providers.

GPOs take a comprehensive approach to sourcing and contracting that not only considers the competitive price offered by suppliers but also the quality, reliability, and stability of supply. GPOs recognize and reward quality while encouraging a healthy market which generally includes multiple manufacturers.

GPOs also work to expand the overall number of manufacturers, including encouraging new suppliers to enter the market.

Now, I have spoken to who GPOs are. I would now like to take an opportunity to touch on who we are not. As many in the room have noted, traditional healthcare GPOs are not PBM-owned, rebate aggregator GPOs, also known as rebate GPOs.

Traditional healthcare GPOs have a different role, different business model, and we serve different settings in the healthcare supply chain.

PBM-owned rebate GPOs work primarily in the retail prescription market with health insurance companies and plan sponsors, aggregating rebates earned on purchases by the PBMs themselves.

The FTC recently acknowledged the distinction between traditional healthcare GPOs that I represent and PBM rebate aggregators, noting that, quote, PBMs refer to these entities as group purchasing organizations. Though they do not perform traditional GPO functions.

In contrast, the traditional healthcare GPOs that I represent are U.S.-based and serve American hospitals and providers, not retail pharmacies and pharmacy chains. Thus, we do not participate as part of the Medicare Part D program.

Traditional healthcare GPOs are fully transparent with their provider members, do not take possession of product, and are focused on getting an appropriate and fair net price.

GPOs predominantly source medications used in site-of-care settings and negotiate point-of-sale price reductions. Any post-sale rebates earned on member purchases are passed through entirely to the providers that earn them.

Flexibility for providers and suppliers is integral to the GPO business model, and actual pharmaceutical purchases are made by the providers, not guy GPOs.

In all these ways, the interests of GPOs are entirely aligned with their healthcare provider members.

Thank you again for the opportunity to provide our perspective to the subcommittee. We look forward to working with you to ensure that patients and providers have affordable access to medications, and I am happy to answer any questions you may have.

[The prepared statement of Ms. Boliver follows:]

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

Mr. Griffith. Thank you very much.

I now recognize Mr. Gelfand.

Mr. Gelfand. Thank you. Are we on?

Mr. Griffith. You are on.

STATEMENT OF JAMES GELFAND

Mr. Gelfand. Great. Chairman Griffith, Ranking Member DeGette, and members of the subcommittee, thank you for the opportunity to testify today. I am James Gelfand, president and CEO of the ERISA Industry Committee.

ERIC is the only national association that advocates exclusively on behalf of large employers regarding health, retirement, and compensation policies.

Our member companies provide coverage through self-insured health benefit plans to tens of millions of workers and families.

When an employee fills a prescription, the employer and the patient pay the bill. On average, ERIC member companies pay 80 percent of healthcare costs.

Unfortunately, healthcare and prescription drug costs continue to rise much faster than the economy grows. Should this trend continue, the costs will simply be unsustainable.

Employers are serious about providing affordable access to healthcare and being good fiduciaries, but when plan sponsors attempt to hold vendors accountable, they are met with opaqueness. They are told to go fly a kite. The data is not theirs to access.

According to a 2025 survey, one-third of employers cannot get and -- complete claims data for their own plan. Four in 10 employers said their vendors simply refuse to provide access at all.

Employers are burdened by the costs of fraud, waste, and abuse, and yet the system often

hides or even encourages it.

Despite our concerns with high launch prices and patent gamesmanship, I am here primarily to talk about middlemen.

According to a recent report, 59 percent of drug expenditures were retained by manufacturers in 2022, and the balance -- 26 percent for PBMs, 10 percent for wholesalers, and 5 percent for pharmacies.

The report found that drug margins were 31 percent for PBMs, 6 percent for wholesalers, and 3 percent for pharmacies.

Wholesaler pricing practices and limited transparency add to higher costs. Congress recently took action to delink PBM compensation from the list price of drugs, but wholesalers appear to make the majority of their profit from the small percentage of branded drugs that they distribute.

GPOs -- and I mean PBM-owned GPOs -- have diverted billions of rebate dollars from employers by renaming those rebates as fees. We are thankful that Congress has said that this must end.

But policymakers must not overlook the PBMs' and GPOs' new, overseas, drug-branding entities that add a massive secret spread price to the cost of medications.

Consultants' and brokers' compensation may also be tied to drug spend or vendor selection. It is imperative that this is disclosed to employers. Can you imagine a greater conflict of interest than getting paid to steer clients to a specific vendor, or getting paid by that vendor for every prescription that is filled?

More transparency is also needed for the drug purchasing collaboratives operated by those very entities.

The bottom line is that our current system seems designed to promote self-dealing, double dealing, arbitrage, and maximizing revenue for middlemen, and not deliver the most cost-effective drugs for patients.

But there are solutions. We deeply appreciate what Congress has done on PBM reform and the administration's recent regulatory action.

But more can be done. PBMs should be ERISA fiduciaries just like employers are, and PBMs should disclose a clear bottom-line number to employers during the RFP process.

My written testimony includes a series of policy recommendations to advance prescription drug affordability. It includes some great bipartisan legislation led by members of this committee.

We look forward to collaborating with you to advance reforms that bring transparency, fairness, and accountability to the prescription drug supply chain. Thank you, and I welcome any questions.

[The prepared statement of Mr. Gelfand follows:]

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Mr. Griffith. Thank you very much.

I now recognize Mr. Hoey.

STATEMENT OF B. DOUGLAS HOEY

Mr. Hoey. Good morning, Chairman Griffith, Ranking Member DeGette, and members of the subcommittee. Thank you for conducting this hearing and invitation to testify. My name is Douglas Hoey, and I am the CEO of the National Community Pharmacists Association.

NCPA represents the family owners of nearly 19,000 independent community pharmacists and long-term care pharmacies, providing vital healthcare services. More than any industry segment, community pharmacists are the frontline of healthcare in America.

Local pharmacists are medication experts and the most accessible healthcare professionals. According to a JAMA study, people visit their pharmacies more than once a month, which is twice as much as they see their primary care provider.

And, when those communities have need that go beyond the everyday, local pharmacies are there. It is my members who are often the last to close and the first to open before a snowstorm, a hurricane, or a wildfire, to make sure their patients are taken care of.

Despite the value our members provide, vertically integrated health insurers and their PBM subsidiaries are systematically eradicating community pharmacies. Pharmacy deserts are growing. One out of eight neighborhoods now lack adequate pharmacy access.

In 2017, I had the privilege to talk to this committee and shared concerns about large PBMs and their impact on patients. NCPA is grateful and applauds Congress for just last week passing the first ever Federal PBM reform legislation, and NCPA will be working with CMS to accelerate its implementation.

These are steps in the right direction to lower costs for patients and employers and provide much needed transparency in the prescription drug supply chain.

However, the supply chain has only grown more vertically and horizontally consolidated since 2017. Since that time, CVS Health acquired Aetna, Cigna acquired Express Scripts, and United Health's OptumRx acquired Change Healthcare.

Meanwhile, in just the last 4 years, pharmacy closures have led to over 5,200 fewer pharmacy options for consumers.

Horizontal and vertical consolidation in healthcare has not produced the efficiencies and price reductions Americans were promised.

Instead it has worsened outcomes, raised costs, and led to rationing of access to care. It has lessened competition and has directly harmed access to independent pharmacies.

The complexity of the pharmacy payment system is dizzying. Independent pharmacies are probably the only small businesses in the whole economy where their biggest competitor owns their data, decides which products they can sell, and how much they will be paid for those services.

Anti-competitive practices, such as patient-steering, opaque pricing games, formulary manipulation, and punitive pharmacy audits, are just some of the ways PBMs abuse their market power.

The big health insurers and their PBMs are truly the judge, the jury, and executioner when it comes to community pharmacies.

On that note, nearly 9 out of 10 of all prescriptions filled in America are for relatively inexpensive generic drugs. Common generic medications like atorvastatin, metformin, and lisinopril are not what is stressing healthcare budgets.

It is prescriptions for specialty medications that are breaking the bank, but specialty medications have no uniform definition. The PBM insurers define "specialty drugs" however it best suits their profits.

And guess who controls where patients can access so-called specialty drugs, guess who conveniently owns and operates their very own mail-order specialty pharmacies, and guess who steers 70 percent of all specialty drug dollars to their specialty pharmacies to the tune of over $180 billion.

No surprise, CVS-Aetna, Cigna-Express Scripts, United Health-OptumRx.

To help foster affordability in our healthcare system, NCPA recommends that Congress prioritize ways to halt and dissolve the horizontal and vertical consolidation that has overtaken healthcare, and specifically the prescription drug supply chain, to ban spread pricing in State, Medicaid-managed care programs and require fair and transparent pharmacy reimbursement, and prohibit steering to PBM-affiliated pharmacies, and stop PBMs from misclassifying specialty drugs.

In conclusion, just as AT&T was busted up 40 years ago, the vertically integrated big health insurers must be dismantled and rebuild to create competition, not oppress it.

Thank you, and I look forward to answering your questions.

[The prepared statement of Mr. Hoey follows:]

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

Mr. Griffith. I thank the gentleman.

I now recognize Ms. Sachs for her 5 minutes.

Ms. Sachs. Thank you.

Mr. Griffith. I have the same problems when I am using those machines. You would think the Technology Subcommittee could get this fixed for us.

Ms. Sachs. Chairman Griffith --

Mr. Griffith. There you go. Thank you.

STATEMENT OF RACHEL F. SACHS

Ms. Sachs. Perfect. Wonderful. Chairman Griffith, Ranking Member DeGette, and other distinguished members of the Health Subcommittee of the House Committee on Energy and Commerce, my name is Rachel Sachs, and I am a professor of law at Washington University in St. Louis where my research focuses on innovation and access to new pharmaceuticals.

Thank you for the opportunity to testify before you today about the role actors, from across the entire prescription drug supply chain, can play in addressing the drivers of high drug costs and how this committee might take steps toward solving these problems.

Today too many Americans cannot afford important medications, and many patients report that they have not taken medication as prescribed due to its cost. Costs are high not only for patients but also for payers, both public and private.

Ultimately, these systemic costs are borne by American households.

In my testimony today, I will first explain how different actors within the prescription drug supply chain contribute to the problem of high drug costs. Key issues include horizontal consolidation, vertical integration, and supply chain opacity.

Second, I will identify potential solutions that act on each entity within the supply chain, offering both broader principles and specific suggestions.

Many actors within the prescription drug supply chain play crucial roles in keeping drug prices high.

Pharmaceutical manufacturers benefit from a combination of government-provided exclusive rights and legally guaranteed insurance reimbursement. This combination limits competition and ties payers' hands, allowing manufacturers to set and maintain high prices over time.

Intermediaries are horizontally consolidated and vertically integrated with other supply chain entities, from insurers to medical practices.

This consolidation limits competition and raises barriers to entry for potential competitors. In 2024, the three leading PBMs processed nearly 80 percent of prescriptions, and all three PBMs are vertically integrated, including with large insurers.

PBMs have been criticized for limiting access to lower-cost products, marking up specialty generics, and steering patients to private-label products from which they profit.

Three wholesalers control 98 percent of the market and are also vertically integrated, including with specialty medical practices.

Wholesalers, whose revenue is often based on a drug's list price, have been criticized for practices including steering patients to higher-priced drugs and limiting practices' choice of wholesalers.

Reported concerns regarding GPOs include contracting practices preventing uptake of new, lower-cost products.

In developing a package of reforms, this committee should keep in mind three common themes. First, for decades, our system has relied on competition to drive down drug prices.

This committee should focus on reforms that make competition more effective, particularly for biosimilars. This committee should support FDA's request to eliminate the distinction for interchangeable biosimilars, conduct oversight of PBMs' use of private-label biosimilars, and adopt reimbursement strategies that encourage price competition between biologics and biosimilars.

RPTR SINKFIELD

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[11:16 a.m.]

Ms. Sachs. Second, where the market is already highly concentrated horizontally and vertically, solutions beyond encouraging competition may be needed. This committee should use oversight to bring transparency to supply chain intermediary business practices and develop data about the impacts consolidation has on companies' business practices. Depending on the results of this oversight, the committee may decide to support structural separation or other related bills.

Third, given both the complexity of the supply chain and companies' motivations to alter their business practices to avoid inactive legislation, it may not be ideal to tie proposals too closely to particular business practices or market structures. It will be important to consider approaches that address reimbursement prices directly. As one example, this committee should consider strengthening the Medicare drug price negotiation program.

In closing, it is important to consider how this committee can support not only affordable access to medications but also innovation in the next generation of therapies. Recent actions threaten the stability of the NIH and FDA and undermine future innovation. This committee can and should shore up Federal funding for biomedical research at NIH and stabilize FDA. Every actor in the supply chain plays a role in keeping prices high, and every actor has a role to play in assuring affordability for both patients and our healthcare system.

Chairman Griffith, Ranking Member DeGette, members of the subcommittee, I appreciate your focus on this important issue, and I look forward to answering your questions.

[The prepared statement of Ms. Sachs follows:]

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Mr. Griffith. Thank you very much. We will now begin questioning. I would ask members not to begin a new question to our witnesses as their 5 minutes expire and would encourage members to submit written questions for the record. I now recognize myself for 5 minutes. And I will tell that I will have a lot of written questions for the record.

Mr. Marin, starting with you. You indicated affirmatively or at least it seems like warm and glowing comment about competition. That immediately triggered my thoughts which then were picked up by Mr. Hoey and Ms. Sachs. So, I ask you, if you like competition, do you think the Federal Trade Commission should break up the three largest PBMs that control 80 percent of the market?

Mr. Marin. Thank you. Thank you, Chairman.

Mr. Griffith. Yes or no?

Mr. Marin. The answer is simply no.

Mr. Griffith. You are not on. While I could hear you, the people back home can't. Okay. Go ahead.

Mr. Marin. Ours is a highly competitive market, Chairman. There are 73 full-service PBMs, all different shapes and sizes, different geographic footprints, different service offerings, different focus.

Mr. Griffith. But you don't deny that 80 percent is controlled by three companies.

Mr. Marin. We see the small players taking business from the big players all the time. And importantly --

Mr. Griffith. I have got to move on because I have got lots of questions to ask, and I am not going to get to all of them.

Mr. Marin. Okay.

Mr. Griffith. Let me go to the next one that has vexed me sometime, and we started fixing it

last week. What we learned -- previously what I have heard is you said you wanted to debunk myths and go after the bunks. So, here you go. This is your chance.

What we have heard is that there have been situations in the past where -- because the PBM gets paid -- and I think we changed some of that last week. But because the PBM gets paid on the list price, they have gone to company A with the manufacturer and said, "We have company A producing this, but there is also company B. And if company A doesn't raise their price, we are going to stick with company B. We are going to take you off of that formulary." And then, once the company A agrees to that, they can then go do the same thing to company B, causing the list price to go up. And I know there is all kinds of rebates and so forth. But, if list price goes up, not everybody is getting that rebate. True or false? Has that happened?

Mr. Marin. That would be an outlier case, Mr. Griffith and Mr. Chairman --

Mr. Griffith. So it has happened, but it is not all the time.

Mr. Marin. Here is the bottom line, is we negotiate lower prices to provide significant value. We saved $330 million.

Mr. Griffith. So how do you explain, when West Virginia decides to set up their own PBM and get out of big ones, that they save 6 percent right off the top?

Mr. Marin. I think more competition is better.

Mr. Griffith. I think more competition is better, too. We will see if we can work on that. Now, let me switch gears and go in a different direction because time is running fast. I am going to start with Crowley, but I invite Mr. Gelfand to get in this discussion, too.

Mr. Crowley, you said something that struck a chord with me. It is not directly related to prescription drugs, but it is. Because sometimes people are denied their drugs. And you said when -- the policy today of some insurance companies is to deny and delay, which then can cause harm and suffering.

So, I submit to you, what if we started looking at -- because I think this is the way it should

be -- we started looking at insurance companies as fiduciaries -- where you come back in -- looking at them as fiduciaries. And, if they intentionally and willfully delay and refuse to provide treatment or coverage for a particular medication and it causes suffering and harm, have them be liable with certain parameters on attorneys' fees, but have them be liable for that damage. What do you think of that?

Mr. Crowley. Yes, Mr. Chairman. I think that anything that advances patient protection and anything that advances medicines to patients is a good idea and should be reviewed.

Mr. Griffith. All right. And, Mr. Gelfand, you said that you thought that PBM should be looked at as fiduciaries, which I don't disagree with you on. Explain.

Mr. Gelfand. So, a fiduciary has a responsibility both to do the right thing for the patients and to try to control costs. There is still going to be tough choices that are going to have to be made, but you would have more confidence if those choices are based on doing the right thing as opposed to making the most profit.

Mr. Griffith. Mr. Crowley is an attorney, and Ms. Sachs is an attorney. Both the ranking member and I are attorneys. We are all fiduciaries for our clients. We lived with that our entire professional careers. And it didn't harm our clients. It helped our clients, and we still made money.

I believe the insurance companies and the PBMs could still make money even if they were used as a fiduciary.

Would you agree with that, Mr. Crowley?

Mr. Crowley. I would.

Mr. Griffith. You would, yes. All right.

Mr. Gelfand, specialty drugs have skyrocketed in recent years. Can you explain exactly what a specialty drug is? Because we have talked about it, but I am not sure the public back home knows about it. And you have 40 seconds.

Mr. Gelfand. It is not actually possible to explain what a specialty drug is because it is a made-up definition. If you look across the big three PBMs, there is variance of up to 50 percent on what they consider to be a specialty drug or not a specialty drug. The definition that I use is an expensive drug.

Mr. Griffith. All right. Fair enough. With that, I am going to yield back, but I will have lots of questions for the record.

And I now turn it over to the ranking member, Ms. DeGette, for her 5 minutes.

Ms. DeGette. Thanks, Mr. Chairman. So, last fall, President Trump threatened major drug manufacturers with ruinous tariffs if they didn't accede to his policy demands which would allegedly reduce the cost of drugs. And now 16 different companies have made secret deals with the White House.

Ms. Reilly, I want to ask you, for your members, what promises have been made by the White House to your member companies as part of those agreements, and what will the member companies have to provide in return?

Ms. Reilly. I appreciate your question, but at the trade association, we don't have knowledge about individual --

Ms. DeGette. You don't have knowledge about that because the details of these agreements have not been made public. Is that correct?

Ms. Reilly. We don't have knowledge because we are a trade association and for antitrust purposes or prior --

Ms. DeGette. Can your companies provide that information to us?

Ms. Reilly. You would have to talk to those companies eventually.

Ms. DeGette. So, Mr. Chairman, I have to ask you, I don't understand what this witness is doing here if she can't give me any details about what her members are doing to try to reduce the cost of drugs. So, I would hope that we can get the members in here to talk about that.

Mr. Griffith. Is that a rhetorical question, or do you want an answer?

Ms. DeGette. No, I really would like to do it.

Mr. Griffith. You would like to do it -- all right. I don't want to use up your time. Go ahead.

Ms. DeGette. When they say they are reducing prices, then they send somebody over here who can't even answer the questions.

Mr. Griffith. Unfortunately, the problem is that all of these agreements have secrecy deals. Each one of them is like a secret.

Ms. DeGette. Well, so, how do we know if they are going to reduce the cost of drugs?

Mr. Griffith. They can't even tell representatives of the -- I don't know the answer to that.

Ms. DeGette. Okay. Well, let's figure it out.

Moving along. Moving along, because you are tough.

Mr. Crowley, I want to thank you for sharing the story about your family and children and what American science ingenuity has done for them. And I want to thank you for your shout out about 21st Century Cures, and to let you know, I am still continuing to work on Cures 2.1.

How important is it, not just to your member companies but to families like yours, that the United States fosters a vibrant and science-driven research ecosystem?

Mr. Crowley. It is vitally important when you think about what it takes to make new and better medicines. It is an entire virtuous circle. So it begins most often with great academic research, oftentimes at or funded by the NIH. That is part of the foundation of the great science in America; it is what has brought us to the lead in biotechnology. It is something we need to advance in --

Ms. DeGette. It is the lead in the world.

Mr. Crowley. The lead in the world, yes, ma'am.

Ms. DeGette. Now, Professor Sachs, you studied pharmaceutical innovation and research

and development. How many fewer grants did the NIH make last year compared to the previous average?

Ms. Sachs. About 24 percent fewer grants.

Ms. DeGette. Twenty-four percent. Do you think that funding fewer grants is likely to lead to fewer treatments and cures down the road?

Ms. Sachs. I think it is likely to lead to fewer treatments. Almost a hundred percent of newly approved drugs have NIH funding underpinning them at some point.

Ms. DeGette. Now, in this administration, the ranks of political appointees at the NIH have greatly expanded. Scientific research grants now need to go through political appointees before approval, and the agency directed the termination of thousands of awards on ideological, not scientific, grounds over the last year.

Professor Sachs, I want to ask you, how has the research community reacted to these developments?

Ms. Sachs. We have certainly seen public reporting that scientists are self-censoring, that they are avoiding using certain words or even avoiding areas of research that are seen as politically disfavored. We have also seen reports that other countries are allocating funding to try to recruit away American scientists, promising greater academic freedom and stable funding.

Ms. DeGette. And that is not going to lead to any better treatments. It is just going to lead to silos.

Ms. Sachs. I don't think so.

Ms. DeGette. All right. Now, let's talk about the FDA, which some can argue is in even worse shape. The FDA has seen a significant brain drain in the last year. Is that correct?

Ms. Sachs. Yes, the drug center lost over 1,100 employees, about 19 percent. And the biologics center lost almost 300 employees, about 20 percent. One report suggested that about 90 percent of senior leadership who had been at the agency a year before are no longer there.

Ms. DeGette. That is stunning. Now, Mr. Crowley, I want to ask you, is it fair to say that this type of staff turnover harms industry confidence and thus investment in new treatments?

Mr. Crowley. Congresswoman, we need a modernized and reformed and bold changes at the FDA. And the core of that has to be the leadership in the staff at FDA. So, when you look at the changes that have been made, it has been very difficult. And you have seen reductions in force. And I am hopeful, confident that we will start to see more and more people coming to the FDA, particularly scientific reviewers, medical reviewers, inspectors. That is the core, the gold standard of FDA for our industry in America and around the world.

Ms. DeGette. Thank you. I have more questions. I will submit them for the record.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentleman from Kentucky, the Chairman of the full Committee, Mr. Guthrie.

The Chair. Thank you very much. Last week, we just approved almost a half-a-billion-dollar increase in NIH.

So, Mr. Gelfand, we wanted you here today because, in the commercial space, employers worked to cover 168 million lives. So, it is a big player in the commercial space. And most of the people here will argue insurance, PBMs, whatever, their job is to get the best price for their customers. Your customer is the employer. You are the one paying the bill. And, yet, you are here saying that you are not getting a fair deal.

So, the marketplace should work. What is preventing the employers from sitting down with us and saying, "No, we are paying you too much, PBM, insurance company; you are supposed to negotiate with us the best price; we think you are keeping too much money," is what your testimony is? What is preventing your employers from making those kind of deals? Freedom of information? Access to information? That is what I wanted to hear.

Mr. Gelfand. For free market to work, there has to be access to information, and there have

to be rules of the roads to ensure that people are playing fairly. And those did not exist at least until last week, perhaps, in parts of the prescription drug supply chain.

The Chair. So, I mean, are people not competing? I mean, why aren't these groups competing against each other?

Mr. Gelfand. One of the challenges that we have had -- and I think the legislation that Congress passed last week is meant to address -- is that intermediaries who are supposed to be representing the purchaser, representing the patients are actually getting paid by both sides of the negotiation. So, if you are getting paid by both sides -- imagine if your attorney was also getting paid by the prosecution; do you think you would end up getting the best plea bargain, or would you probably end up going to jail?

The Chair. Right, I agree. But I know you got small employers, but you have big employers, and they should be able to affect the marketplace. They are big enough to do that. And, yet, I think Jamie Dimon from Bank of America said he couldn't even get the information he needed to reform. And that is a major employer.

And so, I guess the question is: Why isn't this group and this group saying, "Well, if they are going to set you for a hundred, I can set you" -- if they are making that much money, why isn't that dynamic happening?

Mr. Gelfand. So ERIC has multiple member companies that have more than 1 million employees in the U.S. and twice as many covered lives on their health insurance --

The Chair. And even those people can't get --

Mr. Gelfand. One of those employers actually went to one of their big three PBMs and said, "We would like to try things a different way. Why don't we try -- we will have a disinterested third party. We will design the formulary, and we will pay you to service that formulary and run our plant." And the big three PBMs said no, and "Not only will we not do that, but we are confident that the other two won't do it either. So, go pound sand."

The Chair. But there is no competition.

Mr. Gelfand. If those guys can't negotiate -- trust me, 1,000 employers -- employees, 500 employees; they don't have a chance.

The Chair. Well, thank you. Thank you for that.

So, Mr. Davis, the big three wholesalers, or Fortune 15 companies we just talked about, distribute around 90 percent of the prescription drugs. So, we are talking about the vertical integration and the process. Why did you guys argue that that is better for the system to be vertically integrated?

Mr. Davis. Mr. Chairman, thank you for the question. And I actually think it is important to distinguish the degree of diversification within the leading wholesalers. And, to be clear, the top three wholesalers within our membership out of a total of 36, have expanded their business model in certain ways.

I know that there was a chart associated with the majority memorandum for this meeting that identified -- that came from drug channels. That is build-off of the vertical integration that was previously seen and discussed with respect to insurers and PBMs and others.

Well, let me be very, very clear about what wholesalers are doing in diversifying their business and the minority of our leading members that are doing so. On the manufacturing side, on the retail pharmacy side, and on the provider side, they are creating working relationships or networks. They do not own medical practices, as has been alleged by some witnesses on this panel. And they are building out these diversified business practices in large part because they are hearing from their pharmacy customers or other health system customers about their inability to access affordable medication through other sources.

The Chair. Thank you. And, Mr. Hoey, your organization represents independent pharmacies. We hear a lot from independent pharmacies. I would say they are the people whose names are on the Little League uniforms back home, the people that really contribute to the

community.

Mr. Hoey. Yes, sir.

The Chair. Can you just take -- I have 38 seconds -- take what we passed last week? How does that benefit independent pharmacies, PBM reform?

Mr. Hoey. There is multiple facets to it, but it is -- just 30 seconds or less. The reasonable and relevant contracts -- because we had to get an act of Congress for PBMs to give us reasonable and relevant contracts in Medicare part D. Medicare part D is the worst payer. It is a taxpayer-funded program. It is putting pharmacies out of business. So, we believe that this legislation can give us a shot at just reasonable and relevant contracts.

The Chair. So, Mr. Marin, in 10 seconds, do you have a response to that, until he gavels me down?

Mr. Marin. I am sorry. I missed the question.

The Chair. Okay. I am out of time anyway. We will submit it for the record. I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the ranking member of the full committee, Mr. Pallone, for his 5 minutes.

Mr. Pallone. Thank you, Mr. Chairman. I want to follow up on the gentlewoman from Colorado, a ranking member, on these secret agreements with President Trump. But I have to say, I am listening to so many of you talk about, you know, how great the state of medicine is. And we have got this quack Secretary RFK at the top. And, you know, some of you talk about how people are going to go work for the FDA and gold standard. Nobody is going to go work for FDA as long as he is there in charge. You know, the decisions are being made by quack science. You have got -- the gold standard is gone as far as I am concerned with this FDA because of Robert F. Kennedy, Jr. And then some of you talked about how, you know, you want to make investments, which, thank God, over the years, you have made so many investments. But why would you make an

investment today with, you know, with a drug or any vaccine or anything with this FDA? I mean, there is an article today in The New York Times about how the FDA refuses to review Moderna's flu vaccine because Dr. Prasad said -- rejected the company's application.

I mean, you could spend billions of dollars developing a drug, and then the FDA is going to not even consider it because of the quacks. Right? I mean, I wouldn't be surprised if they -- you know, if RFK said, "Oh, rather than do Moderna vaccine, you know, I will watch a Harry Potter film and, you know, use some potion that is created by Harry Potter after you have invested billions of dollars in drugs that are legitimate." I mean, there is no gold standard anymore. The FDA is broken. I mean, that is the bottom line.

But let me just get back to and ask Ms. Reilly. Just a yes or no. Do you have copies of the so-called Most Favored Nations Agreement that your member companies have entered into with the administration? Just yes or no.

Ms. Reilly. No.

Mr. Pallone. Now, how are Congress and the American people supposed to understand the benefit of these agreements without knowing what is in them? I mean, am I supposed to just trust and, you know, the claims of drug manufacturers that this is a good deal for the American people based on the press release they put out? How can I possibly know what is in this program or whether it benefits anybody or lowers prices, Ms. Reilly? Briefly.

Ms. Reilly. Well, I think you will have to take their word for it that they --

Mr. Pallone. But it is absurd for me to take their word for it. I mean, that is not what we do. We don't take the word for anybody. We question. We do oversight. We look into it.

Mr. Chairman, can we --

Ms. DeGette. Will the gentleman yield.

Mr. Pallone. I just wanted to -- let me just do this. And then I -- I was going to ask Chairman Guthrie, but let me ask you because I don't see them. I mean, I just think it is

unacceptable the Federal Government can cut secret deals with these companies and that we don't know anything about it.

So, would you be willing to work with us to try to, you know, get more information about these companies, Mr. Chairman? I mean, that is all I am asking.

Mr. Griffith. About the deals, not the companies?

Mr. Pallone. Yeah. About the deals.

Mr. Griffith. Yeah, I am happy to work with you, Mr. Chairman -- or Mr. Ranking Member in order to try to get as much information as we can without busting up the deals. But, at the same time, I think we do need to know more about what is going on. I am a big believer in transparency. The more we know, the better job we can do as Congressmen.

Mr. Pallone. I appreciate that. I will yield to Ms. Ranking Member.

Ms. DeGette. I just wanted to ask, have we actually seen tangible results? Have we seen drug prices go down because of these secret agreements?

Ms. Reilly. Well, I think it is too soon to tell. That data wouldn't have been available then.

Ms. DeGette. I yield back, Mr. Ranking Member.

Mr. Pallone. Let me just Mr. -- I mean, Professor Sachs. In order to determine whether these agreements save money, don't the public and Congress and experts like you need additional details about how these agreements are going to operate?

Ms. Sachs. There is agreement among the members, and I agree that almost nothing has been made public about these deals. We don't know basic things like which drugs are included, what are the agreed-upon prices, to whom will they be available, and how does the government have any ability to detect and enforce violations of these agreements? Those are all some of the things that you would want to know before --

Mr. Pallone. Well, based on the limited information we have, do you think these agreements are going to meaningfully lower prices for consumers?

Ms. Sachs. I don't think we have evidence of that. If you look at something like TrumpRX, about half of the drugs listed on the site are already available as generics. And sometimes the price of the branded drug on TrumpRX is hundreds of dollars more than the generic price that you could get through GoodRX or cost-plus drugs.

So, if that is representative of the types of products in this agreement, I would be nervous about whether there is any benefits for patients.

Mr. Pallone. Well, I thank you, and I yield back, Mr. Chairman.

Mr. Griffith. The gentleman yields back.

I now recognize the vice chairman of the committee, the gentlelady from Tennessee, Mrs. Harshbarger.

Mrs. Harshbarger. Thank you, Mr. Chairman. And I thank the witnesses for being here today.

Mr. Marin, you will be happy to know, bless your heart, I am not going to ask you one question because the panel has taken care of that.

Prescription drug affordability remains one of the top concerns. And we have a lot to unpack about how the prescription drug supply chain actually works and where costs are truly being driven.

You know, too many prescription drugs carry high price tags and are simply unaffordable for many Americans, especially seniors who live on a fixed income. And, you know, as Mr. Hoey knows, when a patient walks up to my pharmacy and they have to decide whether they are going buy their medication or buy groceries, that is a problem. That is not a statistic. That is real life.

[Chart shown.]

Mrs. Harshbarger. We are going to start out by talking about -- we have had a lot of conversation around rising healthcare costs, and affordability tends to focus only on prescription drug prices. Yet, when we look at the data, including the U.S. Bureau of Labor Statistics

figures -- and I have a chart behind me -- overall prescription drug price growth between 2015 and 2025 has remained below general inflation and below price increases in other major healthcare sectors. So I think it is important that we ground the discussion in facts.

So, Ms. Reilly, how have pharmaceutical prices actually grown over time, and what share do they represent in total healthcare spending? And, since many parts of the healthcare system seem to point the finger only at drug prices, can you help explain what the real cost drivers are that have resulted in hospital costs and other sectors of healthcare skyrocketing?

Ms. Reilly. Absolutely. As I mentioned in my testimony, we really are the only part of the system where our costs do go down over time. And that is because we face competition from branded products, and under 2 years after first medicine gets launched. And then, within 13 years, we face competition from generic medicines where the price drops 90 to 95 percent virtually overnight. We have remained 14 percent of the healthcare dollar as we have for the last 10 years. The next 10 years going forward, we are projected to remain the same in part because we have a system that both balances cost containment because we do face competition and very rigorous competition and allows us to continue to innovate to bring the next generation of medicines to market.

As your chart points out -- and my eyes are testing me -- but at the top of the list, you know, hospital spending has continued to go up. It is the largest part of our healthcare system in terms of spending. We spend almost half of every dollar in healthcare on hospitals. I think a lot of that is driven by things like consolidation in the hospital marketplace, which has allowed costs to go up. And here is a place where I do have some sympathy for payers because, in some markets, there is only one hospital group that owns a certain area, and it can be difficult to lower cost. And there are no generic hospitals or generic doctors. There are only generic medicines, and that does serve as a cost containment.

Mrs. Harshbarger. Thank you, ma'am. You know, I think unaffordability of a lot of specific

drugs is a real problem. Some of that has to do with how our current patent system works.

So, Mr. Gelfand, you know, the large employer health plans see firsthand how patent thickets delay competition and keep drug prices high for workers and retirees. From ERIC's view, how would requiring drug manufacturers to make consistent disclosures to both the FDA and the patent office would help curb abuse of patient practices and lower costs without undermining legitimate innovation?

Mr. Gelfand. Congresswoman Harshbarger, thank you for your leadership on this issue. You know, the FDA, PTO legislation would cut down on litigation time and allow biosimilars to enter the market in a quicker and more competitive fashion. But, right now, inconsistent filings allow branded drugs to dry out litigation and keep biosimilars off the market much longer than Congress intended. Improving those disclosures would preserve the 20 years of patent life that those innovators get, but it would also ensure that the inherent features are not inappropriately sort of staggered in order to make longer patent life.

So, as an innovator, under the legislation, you get to choose. You know, it is trade secrets, or it is patents, but you can no longer jump back and forth between both in order to maximize how long you got exclusivity.

Mrs. Harshbarger. Thank you, sir.

Mr. Hoey, when a small-town pharmacy joins a GPO, it is to lower acquisition costs and keep serving patients. But you testified that PBM-owned, even offshore GPOs collect fees from manufacturers before that money reaches the health plan. In plain terms, what is the difference, and who is really benefiting?

Mr. Hoey. With the offshore GPOs, what the PBMs have done is they have been able to -- they were sniffed out as far as the rebates. People said, "Hey, these rebates aren't all going back to the employer," and so they got shifty, and it is a shell game. So, they opened these offshore, different kind of GPOs to basically launder fees. And, so, the two now employer -- or

manufacturers and employers are basically extorted for fees. Some of those fees are rebates. Some of those fees are offshore in Switzerland or Iceland or who knows where in the world they have their prices.

Mrs. Harshbarger. Well, I will talk to you later. I am out of time. But I yield back, Mr. Chairman.

Mr. Griffith. I appreciate that. Just to set the record straight, apparently some of the IRA-negotiated prices are still somewhat secret as well. So we will work on trying to get transparency across the board.

And I now recognize the gentlelady, Mrs. Dingell, for her 5 minutes.

Mrs. Dingell. Thank you, Mr. Chairman, and the ranking member, and to both of you for holding this important hearing on prescription drugs. And, as you can tell, members on all sides are in agreement that we have got a real problem. In the wealthiest Nation on the Earth, no one should have to choose between buying groceries and affording the medications they need to survive, as my colleague just talked about. And, while I am not a pharmacist, I spent a lot of time in my community pharmacies talking to people, talking to the pharmacists, talking to people that are getting their prescriptions. And drug prices are continuing to increase, along with the healthcare premiums and out-of-pocket costs. It undermines the ability of our healthcare system to ensure patients can get the drugs that they need.

I know there is no one-size-fits-all solution, and we have got to work across all the different portions of this. Being particular, pharmacy benefit managers are a major player in the supply chain that have been allowed to operate unchecked for far too long. We did some commonsense reforms to the PBM industry in the recently passed fiscal year 2026 Labor, Health, and Human Service and Education funding bill, but there is a lot more work that needs to be done.

We have got to continue to fight to strengthen PBM accountability and ensure that Americans can get their medications closer to home and at the pharmacies that they trust. This means

meaningful reforms, not half-baked plans like those that we have heard about this week that claim to lower healthcare costs with few substantive details that explain how they will tangibly benefit patients.

So, for example, why TrumpRX boasts that it will offer direct-to-consumer lower drug costs. In many cases, it is directing people to more expensive, brand-named drugs that won't count for their out-of-pocketed costs or their deductibles. That is not a meaningful solution to lower drug costs. We need to be focusing on improving Americans' health coverage, instead of giving gimmicks to manufacturers.

So, Mr. Hoey, I am going to start with you. To the extent it is true for some medicines, why is it cheaper to buy them without insurance as TrumpRX is claiming to? And why do PBMs tell pharmacies if they cannot give that option, or they will be dropped? And it is true.

Mr. Hoey. Yes, so, PBMs when they process the prescriptions, or when the prescription goes through them, they will spread pricing on it. So, spread pricing is the difference between what they charge the employer and what they pay the pharmacy. So, if they can route that prescription through the PBM, they inflate the cost to the consumer. So, the consumer pays more, the pharmacy gets less, the employer pays more, and the PBM makes more money. So, that is one reason why using your insurance can actually be more expensive than paying cash.

As far as your second question related to the PBMs, they do not want pharmacists talking to patients about lowers costs because they want to route those prescriptions through them where they make more money. There is a bill that is signed to eliminate gag clauses which has been very helpful. But still, PBMs use punitive audits and other techniques to threaten pharmacies and to kick them out of the network if they do things that the PBMs don't like, such as talking about transparency.

Mrs. Dingell. Look, I am sitting in those pharmacies, and they are telling me the truth, and I can give you 10 pills right now that a patient can save a significant amount of money, not 50 cents,

but a significant amount of money, and it is wrong, and the patient is the one getting screwed.

Mr. Hoey. You are right, Congresswoman.

Mrs. Dingell. How can Congress meaningfully address the perverse incentives for PBMs to steer patients toward more expensive drugs.

Mr. Hoey. I am sorry, I didn't --

Mrs. Dingell. How can Congress -- what can we do so that your incentives to also steer patients towards more expensive drugs -- what did we do to cut that off?

Mr. Hoey. One of the things that can be done is for pharmacies and patients to have access to the net price. So what happens, there is a list price, which is the high price, and then a net price. And PBMs, frankly, extort or draw fees --

Mrs. Dingell. "Extort" is a good word.

Mr. Hoey. Yes, ma'am, they do. And getting that net price -- allowing that net price -- allowing that net price, allowing pharmacies to buy at that net price and to be able to sell it to consumers at that net price is one change -- policy change that would help lower drug costs for our patients.

Mrs. Dingell. Unfortunately, I am out of time, so I will be submitting a lot more questions for the record. Thank you, Mr. Chair.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentleman from Florida, Mr. Bilirakis.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it.

Mr. Crowley, your personal story on rare disease is incredibly powerful. As you are well aware, our committee has prioritized policies to help create meaningful drug development like the therapies that impacted your family. Recognizing the challenges to produce medicines for small patient populations, Congress created new incentives in the FDA process to spur orphan drug development. But reimbursement uncertainty still makes this environment particularly difficult,

particularly in cell and gene therapy.

How can we continue to encourage investments in these potentially curative therapies without breaking the wallets of the rest of the patient population?

Mr. Crowley. Great, Congressman. Thank you for your question. And you highlight a very important issue. There are more than 10,000 known rare diseases that collectively affect about 10 percent of Americans. Most of them children, often fatal diseases. Only several hundred of them have cures. So we need to focus on two areas. One is innovation. How do we bring more science, more technology for more biotech companies, allow our largest biotech and pharmaceutical companies to work in these rare diseases. So, we need to reduce the complexity of our clinical trial system. We need to modernize the FDA so that they look again at each of these rare diseases and each proposed technology, individually, and apply more sophisticated regulatory tools and technologies that they have. If we do that, you will see more capital flowing into rare diseases. We need to reduce the cost of what it takes.

You know, when I developed rare disease medicines for very small patient populations, we invested almost a billion dollars in each rare disease. Important medicines, for my children and others, but only thousands of children. That is too much. That is not sustainable. So what can we do to bring down the cost of development, bring certainty and predictability to the regulatory process, enhance again the regulatory tools and technologies, and, on the other side, ensure access to these medicines?

What you highlight, Congressman, the cell and gene therapy area, that has the potential to finally cure so many of these rare diseases. And what we need to do is make sure we are not only simply making these great medicines, but everybody has access to them. So novel payment methods, looking at the effectiveness and affordability of these medicines will be vital to ensure that, when there is a cure, an effective treatment, that everybody has access.

So I would encourage this committee and this Congress to continue to work toward that goal.

Mr. Bilirakis. You have my commitment.

Mr. Crowley. Thank you.

Mr. Bilirakis. While promoting the development of innovative therapies is key, we also must ensure that patients again would have access, and affordability is so very important.

Mr. Murphy, I understand that current PBM incentives could lead to PBM prioritizing drugs with higher rebates and fees tied to higher list prices rather than prioritizing the lowest total cost to the patient.

So the question is: Can you elaborate further on how these incentives affect formulary coverage for low-cost generics and biosimilars, as well as how this ultimately impacts patient access and cost sharing, please? This is for Mr. Murphy again.

Mr. Murphy. Thank you for the question. So, it is true we see significant drop-off in formulary coverage of generic medicines as a result of a number of practices. You know, I would go and note that, in 2025, the Medicare part D formularies, 57 percent of covered generic drugs were not even on generic formulary tiers. And that was just this current formulary here.

So, you know, in answering your question, I think one of the most important things we would advocate for is that we start to really recognize that, as that time limited period of monopoly pricing comes to an end and generic products are approved by the FDA, they be prioritized for coverage because of their cost savings. And then patients actually pay from an out-of-cost standpoint on the actual net cost of those generic medicines that are offered to them. Because, ultimately, at the plan level, or the employer level, we talk a lot about discounts and rebates. But, ultimately, what we want to get to is the point where the patient is actually paying less money when he or she picks up the prescription at the pharmacy counter.

Mr. Bilirakis. Exactly. Thank you. Yeah, I guess I better yield back, Mr. Chairman. I don't have much time left. I will submit. Thank you.

Mrs. Harshbarger. [Presiding.] Thank you. The gentleman yields back.

And now I yield to my friend, Representative Barragan, from California for her 5 minutes.

Ms. Barragan. Thank you, Madam Chairwoman.

Mr. Marin, I am going to just ask you a very easy question. I didn't hear an answer the first time it was asked. The three largest PBMs, which are owned by CVS Health, Cigna, and United Health Group control nearly 80 percent of the PBM market, correct?

Mr. Marin. That is correct. That is correct.

Ms. Barragan. Okay. All right. Well, that is why I think it is hard to believe when you say, when there is competition, prices come down. Because, if there is three that own 80 percent, then there is not a lot of competition. I know what you are saying; you are saying there is others, and there is a lot of little or others that seems like --

Mr. Marin. Congresswoman, it is more than --

Ms. Barragan. It makes it hard to believe a statement you say because you got to dig in further. It is not a good start.

I also understand from the Federal Trade Commission that the top three PBMs process 79 percent of approximately 6.6 billion prescriptions dispensed by the U.S. pharmacies in 2023, while the top six processed more than 90 percent.

We have heard Mr. Gelfand mention PBM margins are 31 percent. Is that right, Mr. Gelfand?

Mr. Gelfand. Yes.

Ms. Barragan. So, tell me, what does that do for prices for consumers?

Mr. Gelfand. So, every supply chain entity that adds fees and margins, that just means higher price for consumers. At the end of the day, consumers are paying about 25 percent of the cost. The employers are paying the other 75 percent. That 75 percent comes out of your wages. It comes out of your take-home pay. So, you are paying all of it one way or another, and that adds up big time.

Ms. Barragan. Thank you. I am looking at a report that shows the three biggest pharmacy benefit managers made more than $7.3 billion over 5 years marking up the prices of specialty generic drugs for cancer, HIV, and other conditions.

Mr. Marin, you know, when people are sick with cancer, when people are suffering and their family see a loved one, and they are trying to get a specialty drug, that is hard enough. To then have to worry about the price of them getting their drug is serious business. I mean, I think about my own sister and how hard it was for her to get specialty drugs, and then you look at the price tag; this is why there is a focus on PBMs. This is why there is a focus on your industry.

You come in here and you say, "Oh, there is just missed facts, misconceptions." You are part of the reason why people suffer and why it is making it harder for people with cancer and HIV to get their drugs.

Mr. Marin. Congresswoman?

Ms. Barragan. There is no question pending for you to say anything, sir.

Mr. Hoey, I want to thank you for the work that pharmacists do. When I think about my father who died when I was 23, he was always going into a local pharmacy -- pharmacist and who knew our family by name, who dispensed a drug temporarily if the insurance company hadn't filled it. And, so, I want to thank you for the work.

You have also mentioned some of the problems and some of the concerns. One of them you talked about was horizontal and vertical consolidation. Most people watching today don't know what that means.

[Chart shown.]

Ms. Barragan. I have a chart, and if you can see it from there, this is a chart -- if we can pan out here -- where those at the top own both the insurance company, the PBM, and the pharmacy and the provider.

So, can you explain to the American public what this means for them in pricing?

Mr. Hoey. Yes, and Congresswoman, I am sorry for your loss. And our members are -- that is the type of work our members do, is have those relationships with patients.

To your question about the vertical integration and consolidation, what it means to patients is that that patient frankly is controlled. Their healthcare journey from the time they get -- they see the doctor, get a prescription, get that prescription filled, maybe have to go to decide which health system, which hospital, there are three entities that control that journey because they are all the same.

So, for example, CVS, Aetna -- CVS -- people think about the brick and mortar pharmacies. That is probably the smallest part of their business. They own Aetna, which is the health insurer, and they own Caremark, which is the PBM.

So, if a patient is prescribed a prescription, the doctor or the pharmacist is sometimes overruled by the PBM because the PBM makes more money off of a different drug. So the PBMs are actually practicing medicine. That is one stage. Then the patient is trying to get their drug, and the PBM can either block it or acquire a prior authorization, or they can say, "Patient, you cannot go to that pharmacy; you can only go to my specialty pharmacy."

So every step of the way, through the vertical integration, the patient choices are compromised. And, when those patient choices are compromised, there is less competition and higher prices.

Ms. Barragan. Thank you. I yield back.

Mrs. Harshbarger. The gentlelady yields back.

And I now recognize my friend and other pharmacist in Congress, Representative Buddy Carter from Georgia.

Mr. Carter of Georgia. The oldest pharmacist in Congress by the way. Thank y'all all for being here.

Mr. Marin, in your organization, PCMA often claims, with caveats, of course, that your

industry saves consumers and patients billions of dollars. As you heard, I am a pharmacist. So I know that that is not true. I know what is going on. In fact, PCMA says that PBMs make healthcare more affordable and accessible for all Americans. I would also refute that.

Yet the Federal Trade Commission has found that the three PBMs, the big three PBMs, are charging enormous markups on dozens of lifesaving drugs and reimbursing their affiliated pharmacies at a higher rate that they pay their unaffiliated pharmacies. I know because I had an unaffiliated pharmacy. I had three of them. I know what the reimbursement was.

In 2022, for example, a large share of the drugs marked up by more than 1,000 percent -- 1,000 percent -- were taken with patients with cancer, with pulmonary disease, with multiple sclerosis, a number of different things that they had to have these medications for.

In fact, the pulmonary hypertension drug, tadalafil, pharmacies purchased the drug at an average -- the pharmacies purchased the drug at an average of about $27 in 2022. But the three big PBMs marked up the drug by $2,079. They were paying their affiliated pharmacies $2,106 on average for a 30-day supply of the medication. That is an average markup of over 77,000, 77,000 percent.

In light of these findings, Mr. Marin, can you still stand by PCMA's claim that PBMs made healthcare more affordable and accessible?

Mr. Marin. Yes, Congressman. I appreciate your passion on these issues, and I look forward to working with you as well. Yes, we saved $333 billion last year.

Mr. Carter of Georgia. How can you explain when you marked it up 77,000 percent?

Mr. Marin. I would have to look at that case specifically, Congressman. But let me tell you, I understand the concern about independent pharmacies across the country. They are critically important to the work we do. We can't do it without them.

I think there is some good news from PBMs writ large, reimbursing them at higher rates, for example, moving to cost-plus contracts, reimbursing for the clinical services that they provide. But

there is still a lot more work to do, and I look forward to doing that with you.

Mr. Carter of Georgia. Well, good, I hope that you are sincere. I have no reason to believe that you are not. And I am going to hold you to it, you know that.

Let me ask you something. The Federal Trade Commission recently reached a settlement with Express Scripts to lower drug costs and improve transparency.

Chairman Ferguson, who I think personally is doing a great job, the settlement requires Express Scripts to make fundamental changes to its business practices that increase transparency and are projected to reduce patients' out-of-pocket cost for drugs like insulin by up to $7 billion over 10 years. This is important.

Mr. Marin, as the National Trade Association representing PBMs, will PCMA commit to adopting the key terms of that settlement as a standard operating practices across all of its member companies?

Mr. Marin. Thank you, Congressman. Look, I mean, there is a lot of good stuff in there. There is also a lot of good stuff that the industry was already moving toward, right? Moving to cost-plus contracts, for example, higher reimbursement rates for independent pharmacies, zero-dollar drug lists for patients with no cost sharing, enhanced transparency, passing through all rebates.

Mr. Carter of Georgia. Understood.

Mr. Marin. The legislation that you passed also just 2 weeks ago includes tremendous transparency requirements.

Mr. Carter of Georgia. Well, thank you. We are very proud of that. I am very proud of it personally.

Mr. Marin. So I think that --

Mr. Carter of Georgia. Well, let me ask you something. What about GPOs? They are based in foreign countries. Are you going to try to bring them back to America?

Mr. Marin. Those are strategic business decisions that I would want to ask the individual companies to answer. But, overall, look, we use our purchasing power --

Mr. Carter of Georgia. Wouldn't you encourage them to come back to America? I mean, then, that is the focus of this administration is to try to get more manufacturing and more business back here in America.

Mr. Marin. I don't disagree.

Mr. Carter of Georgia. Good. So I hope that we can count on you to help us with that and count on your companies to help us with that.

Mr. Marin. And I think we can help get you the facts around those situations.

Mr. Carter of Georgia. Okay. All right.

Mr. Hoey, thank you for being here. I appreciate it. We both know that PBM reform has been a long time coming, and the aforementioned wins that we had last week in the Consolidated Appropriations Act were significant. Perhaps some of the most significant reforms in PBMs that we have had ever. And I am very proud and very thankful to the members of NCPA for their help and their advocacy of this. Because, after all, folks, we all want the same thing. We want affordable, accessible, quality healthcare. Pharmacists are the most accessible healthcare professionals in America. Ninety percent of all citizens in America live within 5 miles of a pharmacy. They are the most accessible healthcare professionals. And, as they begin to close, we impact accessibility to healthcare.

I hope, Mr. Marin, that you will keep that in mind and that your organization will keep that in mind.

Mr. Marin. You have my pleasure. Thank you, Congressman.

Mr. Carter of Georgia. Thank you, and I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentlelady from Washington, Dr. Schrier.

Ms. Schrier. Thank you, Mr. Chairman, and thank you to our witnesses. Two things can be true. At the same time, innovation is important to the American economy, and every American should be able to afford their medications.

As a pediatrician, I just have to start with EpiPens, they have been around for decades. People with severe allergies carry them around in case they have a life-threatening allergic reaction. EpiPens can cost over $600 out of pocket. And I just want to say that is outrageous, especially for kids who have to have one at home, one at school every single year. And I want to call on Viatris and all manufacturers of EpiPens to drop the price, or we will take congressional action.

Turning to vaccines, also, a pediatrician -- and this administration's war specifically on mRNA vaccines -- just yesterday, as Mr. Pallone said, we learned that the FDA refused to even review Moderna's breakthrough MRNA flu vaccine, even though the FDA had previously helped guide the company's study design.

Many of you have talked about the importance of American innovation. Mr. Crowley, Moderna is a member of BIO. What impact does this inexplicable decision that radically deviates from FDA practice have on American innovation?

Mr. Crowley. Congresswoman, we share your belief in the importance of vaccines. How in the world are measles coming back? We have an entire task force at BIO advancing the interest of vaccines for the American people and ultimately to the entire world. And, while I can't comment on any specific company or decision, I think we are in agreement, though, very broadly, we are concerned about shifting standards. We need consistency. We need predictability from our regulatory bodies, and we need acceptance of vaccines -- you know, perhaps, no biotechnology has done more to change and improve human health globally than vaccines.

Ms. Schrier. Thank you for acknowledging that. Yes. Just hit -- emphasize that -- double click on it. If you have an unpredictable FDA, and there is no guarantee your medicine will even be reviewed -- it depends on the whim of whoever is in charge -- you may not decide to innovate.

Next, I want to turn to the Vaccine Injury Compensation program. Secretary Kennedy continues to dismantle vaccine confidence and infrastructure in this country. He has spent decades elevating fringe conspiracy theories by continuing as just one example to falsely claim the vaccines cause autism. And I will note that his own NIH health director, a physician, said last week that he has, quote, "not seen a study that suggests any single vaccine causes autism."

Now, RFK, Jr. is threatening the National Vaccine Injury Compensation Program. This is a really important program. It protects patients and manufacturers. Patients with compelling evidence of serious vaccine injury receive financial compensation. And I want to be really clear: This is extraordinarily rare, but it can happen.

Impacted patients, they deserve an accessible, affordable pathway to get payment. And the data show that patients are more likely to succeed in getting compensation through VICP than they would in a lawsuit.

And I just also have to mention that Secretary Kennedy has made nearly $2.5 million recruiting people to sue vaccine manufacturers. And, if VICP goes away, he benefits from lawsuits.

Mr. Crowley and Ms. Reilly, both of you, if you have time, why is it important to have a strong VICP, and are you concerned by the Trump administration's threats to add autism to VICP?

Mr. Crowley. The VICP program has worked, as you indicate, Congresswoman for decades, and it compensates people in those rare instances who are harmed. Anything that threatens that system, we are very concerned about. We, too, have seen no study that shows that autism is linked to any vaccine. And any change needs to be based on strong science that is well vetted, and that is a great concern of ours.

Ms. Schrier. Ms. Reilly?

Ms. Reilly. I would echo what Mr. Crowley said and note as well, as he mentioned, the reason the VICP was put in place in the first place was bipartisan. And it was done because we saw vaccine manufacturers fleeing the market.

And the last thing we want in this day and age is to have vaccine manufacturers leaving the market. It is vital. And I would agree, also, with what John said. I think the one thing that has been studied significantly is any connection between vaccines and autism -- and there is no study that suggests that vaccines cause autism.

As a mom of four, I can empathize with patients who are searching for what may be causing their child's autism, but I can affirmatively say it is not due to vaccines.

Ms. Schrier. Thank you for your answers. Just to emphasize, we need VICP to protect patients. If it goes away, RFK, Jr. will profit heavily, and patients will be harmed, and we will lose innovation. Thank you. I yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentleman from Pennsylvania, Dr. Joyce.

Mr. Joyce. Thank you for yielding, Mr. Chairman. One of the worst examples that we have seen showing the incentives in our drug supply chain are broken and don't respond to market forces was a launch of the Humira biosimilars.

It was particularly alarming to me to hear from manufacturers that, despite the dramatic decrease in list price, they were having problems getting any sort of traction with formulary placement because PBMs prefer the higher cost branded medication because it meant a bigger rebate.

We even saw one company in particular launch two products: one at the higher cost, and one at the lower cost. And, within the same company, they saw that the higher cost drug received more volume.

Honestly, it seems insane that, given the PBM mission of lowering drug costs, your companies, Mr. Marin, would seemingly prefer to keep prices high. Now, to be fair here, I have heard from employers and the broker consultant companies that they work with to design their PBM RFPs, that they often build in rebate guarantees as part of their pharmaceutical contracts. I am

concerned that these rebate guarantees, especially considering the aforementioned Humira example shift drug pricing behavior and incentivize manufacturers to launch at higher list prices and PBMs to prefer that higher list price, higher rebate drugs, even in situations when lower rebate alternatives might be available.

Mr. Marin, can you explain what a rebate guarantee is?

Mr. Marin. I think it is important -- hello? Yeah. There we go. So, PBMs, obviously, use rebates to help drive down the cost of drugs. Rebates now must be passed through fully to the employer.

Mr. Joyce. Do you feel that the guarantees that the rebates have play a role in PBMs placing preferential treatment of high list prices over lower list price drugs?

Mr. Marin. To the extent that occurs is because we were able to negotiate a lower price.

Mr. Joyce. That generates a rebate then.

Mr. Marin. Well, the issue is what employers choose as the design of their program.

Mr. Joyce. But a higher list price would generate a higher rebate, correct?

Mr. Marin. Of course.

Mr. Joyce. Mr. Gelfand, do your member companies include rebate guarantees, and, as a part of their PBM RFP process, do you feel that these guarantees lead to overall lower costs within the system?

Mr. Gelfand. So, prior to the legislation that Congress recently passed, the rebate guarantee was one of the few metrics that an employer could judge apples to apples between the different PBMs that they would be choosing for -- to contract with.

But, as you, I think, are pointing out, choosing the highest rebate guarantees is kind of like going to one of these stores where everything is always 60 to 70 percent off. You have no context. So you don't actually know if the net price is a good price. We think that that is going to go away thanks to the legislation that is going --

Mr. Joyce. Without that legislation, that impact was being felt by businesses, by patients, and by America at large.

Mr. Marin, would you say that the report that I will mention, which addresses affordability, and insurers and PBMs have an incentive to manufacture and own generic and biosimilar medicines -- do you feel that that incentivizes companies to form their own companies to manufacture their own drugs?

Mr. Marin. No, Congressman. I think, look, I think PBMs, in general, believe that biosimilar competition drives down costs. That is what we do. And more biosimilar --

Mr. Joyce. A 2025 analysis performed by the 46brooklyn found that, on a product level basis, Cigna's Quallent pharmaceuticals offered products that were 33 times higher and more expensive than the average wholesale price based on the cheapest average wholesale price. Do you think this report is accurate?

Mr. Marin. I am not familiar with the report, Dr. Joyce.

Mr. Joyce. Allow me to enter into the record how PBMs can use private labor drug products from July's 46brooklyn publication.

Mr. Griffith. Without objection.

[The information follows:]

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

Mr. Joyce. Vertical integration across our entire healthcare system has become a major concern for this committee. Many members have mentioned this today.

Mr. Gelfand, major wholesalers have made acquisitions of oncology and specialty physician practices over the recent decade and are operating specialty group at higher costs oncology and other specialty drugs.

How do these acquisitions potentially increase the demand for high cost drugs?

Mr. Gelfand. Yeah, I know that we are always told that vertical integration is going to lead to efficiencies, but it never actually seems to work out that way.

Mr. Joyce. In this case, does that vertical integration lead to efficiency?

Mr. Gelfand. We believe that it leads to higher --

Mr. Joyce. Does that lead to higher cost.

Mr. Gelfand. We believe that it leads --

Mr. Joyce. Does that impact the patient?

Mr. Gelfand. That means the patient will be paying a higher out-of-pocket, a higher deductible, higher co-insurance, and higher out-of-pocket max.

Mr. Joyce. Thank you, Mr. Chairman. My time has expired. I would submit additional questions for review. Thank you all for being here.

Mr. Griffith. The gentleman yields back.

I now recognize the gentlelady from Massachusetts, Mrs. Trahan.

Mrs. Trahan. Thank you. Thank you to the Chair and the witnesses for being here today. Access to affordable, innovative, and lifesaving therapies helps patients manage acute and chronic disease and live healthier, fuller lives. And, when patients can access the medicines that they need, it can also lower long-term healthcare costs by preventing avoidable complications and hospitalizations.

We also need to be honest about what Americans are experiencing right now. Accessing and affording the care that they need is one of the defining issues for families across the country. The anxiety that high prices create is real. It is not a hoax. Prescription drug costs are a major part of that burden for so many Americans. And affordability is not just required at the pharmacy counter; it is also about whether we are building a system that can deliver the next generation of cures in a way that is competitive, resilient, and accessible to patients.

Other countries, including China, are moving aggressively to attract clinical trials and accelerate biomedical innovation. At the same time, we are seeing real uncertainty in cuts in Federal health research dollars here at home, which risks weakening the very ecosystem that has made the United States the global leader in biomedical breakthroughs.

If America falls behind, we risk weaker supply chains, less domestic capacity, higher prices, and a reliance on other countries for our lifesaving medicines and treatments.

That is why today's hearing really matters. If we want patients to access the medicines that they need, we have to understand why prices are high, where the dollars go, and how this system can work better for the people it is supposed to serve.

China has a clear strategy to lead the future of medicine development, and their role in the global clinical trial pipeline has grown dramatically over the last decade. Today, China-based companies account for significant share of global trials starts and are running phase 1 trials faster and at a lower cost than in the U.S.

Ms. Reilly, in light of this global competition, what concrete steps should Congress take to strengthen America's clinical trial and biomedical innovation ecosystem, including ensuring stable Federal research investment so that we remain the world leader in developing new cures without compromising safety or patient protections?

RPTR MOLNAR

EDTR ROSEN

[12:17 p.m.]

Ms. Reilly. Thank you for the question, and I could not agree more the importance of having the U.S. maintain its lead in biomedical innovation and research. I think there are a number of steps that we should be taking to ensure that we remain that leader.

China had a multi-decade plan to overtake the U.S. They have streamlined regulations. They have added to their workforce. They are graduating 100,000 more STEM grads in the U.S. on a regular basis.

They are doing everything they can to overtake us, and to all the points you made, they are having success in doing that.

We still remain the global leader, and to keep that in check, we do need to do some of the things that Mr. Crowley mentioned before, in terms of improving the process at the FDA.

We need to make our clinical trials more efficient; we need to lean on technology like AI; we need to centralize IRBs, other things that would bring costs down and increase speed in the process.

At the same time, we need to keep what does work in our system. Strong intellectual property protection is important. Our companies make big bets. They spend over $2 billion to bring a medicine to market.

So having certainty in intellectual property is key, but also having a predictable, transparent, regulatory system is crucial.

And as you mentioned, the ecosystem that exists in the United States, that cooperative research between academia, government, and industry, has been part of the reason why the U.S. overtook Europe 40 years ago in terms of bringing new medicines to market, and we cannot let that go away.

Mrs. Trahan. Thank you. Appreciate that answer, thoughtful.

As we think about innovation and competition, I think we also have to think about preparedness. This committee has often been able to work together on health preparedness, and I hope we can continue that tradition as we look ahead to reauthorizing important preparedness programs, because at the end of the day, being ready for the next public health emergency is something that we all share a responsibility for.

We have seen in recent years that having flexible platforms already in place, whether for vaccines, diagnostics, or therapeutics, can make a difference between responding in months instead of years.

Mr. Crowley, how important is it that we invest in platform technologies and strong health data infrastructure that can help accelerate clinical trials, support faster development of new treatments, and strengthen our ability to respond quickly when new threats emerge.

Mr. Crowley. Congresswoman, thank you for your leadership on this issue. Preparedness is what it is all about when it comes to the next natural COVID that we may see, the flu, whatever it may be, or a bad actor in bioterrorism.

And as a former intelligence officer, I have a uniquely vivid perspective of the threats that we face.

And when we use platform technologies -- and I will give you the example of the mRNA technologies and what we were able to do with that technology -- it didn't just magically appear when COVID appeared. It represented decades of academic work, work at our smallest companies, our biggest companies, to take that platform technology, to utilize the entire ecosystem to come together to tackle that problem was essential for public health and essential for our national security. So platform technologies are vitally important.

Mrs. Trahan. Thank you.

Thank you, Mr. Chair. I yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentleman from Ohio, Mr. Balderson, for his 5 minutes, and then we will do at least one more after that. So we will get Mr. Veasey before we break for the votes.

Mr. Balderson, you have 5 minutes.

Mr. Balderson. Thank you, Mr. Chairman. Thank you all for being here today. My first question is going to go to Mr. Crowley. Thank you for your story this morning that you shared.

Your testimony highlights the importance of reducing unnecessary regulatory barriers at the FDA as a means of lowering costs. A significant driver of these costs is the clinical trial process itself.

How can the FDA accelerate and modernize the trials to expedite early-stage drug development, especially as competitors like China streamline their regulatory pathways and seek to undercut U.S. leadership in biotechnology?

Mr. Crowley. Congressman, I think we can look to what is directly under the FDA control. So for instance, the requirements to get into clinical studies have become overly bureaucratic, arcane.

For an example, what it takes, the animal preclinical testing, I think we need to step back and even begin with the question of why do we test our medicines on animals first?

Here we did see, I think, important improvements, new guidance from the FDA last year, that reduced the requirement without at all threatening patient safety.

So that is what the FDA, one example of what they can do, to shorten the timeline, reduce the cost and complexity of getting into the clinic.

Another area that I think the FDA can influence but doesn't directly control is the clinical trials. When we develop medicines for rare disease in my biotechnology company, I knew exactly what we needed to do to get into clinical studies. It wasn't easy, but we knew what we needed to do.

Once the FDA cleared us into the clinic, it was another year of working with academic centers, hospitals, going through their institutional review boards -- and most of them have their own -- their

ethics committees, separate contracting, separate informed consent -- that is part of the system that we can make much more efficient.

So for instance, if hospitals and major academic centers would use centralized IRBs, it would significantly cut the time and cost of getting into clinical studies.

Mr. Balderson. All right. Thank you very much. Well done.

My next question is for Mr. Hoey. I represent a very rural district, and not only is access to healthcare a problem, but access to pharmacy services is growing more challenging as well.

A 2025 FTC report -- I think it has been talked about here this morning -- examined PBM pharmacy contracting practices and found that internal PBM documents suggested rural pharmacies are often forced to accept take-it-or-leave-it reimbursement rates.

Could you elaborate on the specific challenges rural pharmacies face when negotiating contracts with PBMs and how these practices may affect access to care in rural communities?

Mr. Hoey. Thank you, Congressman. Yes, take-it-or-leave-it contracts are part and parcel to the so-called negotiations between pharmacies and PBMs.

PBMs hold all the leverage. They hold the patient lives. So if the pharmacy does not sign basically whatever is put in front of them, with very little negotiation -- I am sure our friends at PCMA will say there is lots, there is robust negotiation, but in reality, it is a take-it-or-leave-it contract.

So these pharmacies are forced to sign contracts that oftentimes will pay them below their cost to even acquire the drug.

And yes, rural pharmacies, as well as pharmacies in underserved areas, in urban areas, suburbia, they are all taking these contracts in which they are paid below their cost to acquire the drug.

And as a result, 5,000 pharmacies have gone out of business in the last 4 years alone. There is 5,000 fewer pharmacy choices in the last 4 years alone. It is a systemic process -- or it is a systemic problem, and, in fact, pharmacy deserts, especially those in your district in Ohio, and across

the country, are growing because of these take-it-or-leave-it contracts.

Mr. Balderson. Thank you.

My last question is for Mr. Murphy. Mr. Murphy, the U.S. generics market has historically driven price reductions of up to 95 percent and expand patient access through increased competition.

Some stakeholders have raised concerns that provisions of the Inflation Reduction Act may affect the long-term viability of the generic market. Can you explain how the IRA could alter incentives for generic drug development and market entry and what implications that have for the future competition and patient access?

Mr. Murphy. Thank you for that question. So certainly, you know, our view is that the free market and pro-competitive opportunity for generics and biosimilars to compete, to bring prices down, is the most sure-fire way for us to save money on medicines over the course of the U.S. healthcare system.

And obviously, parts of the IRA were very well-intentioned, and certainly make a lot of sense, but, you know, aspects of implementation, like CMS implementing the biosimilar launch delay provisions were done in a way that actually reduce the predictability of the ability of biosimilar manufacturers to get on the market.

And so they, you know, have a thumb on the scale against development in those cases now that we would really love --

Mr. Balderson. Okay.

Mr. Murphy. -- CMS to fix, or Congress to intervene.

Mr. Balderson. Thank you. I need to yield back so we can keep moving. Thank you for your testimony.

Mr. Chairman, I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentleman from Texas, Mr. Veasey, for 5 minutes.

Mr. Veasey. Thank you, Mr. Chairman.

As a reminder, Americans pay far more for medications than any other country in the world, and that is a real problem, and it is going to require real solutions.

And I just want to take a second to be honest with the American people, and I don't know if anyone else has noticed this pattern, but the President loves to take existing programs and institutions or ideas and slap his name on them.

First it was U.S. Institute of Peace, then the Kennedy Center. And now it is this TrumpRx, and TrumpRx is being marketed as a drug pricing breakthrough. For those of you that don't know, I want you to take a closer look at what TrumpRx actually is and what it is not.

TrumpRx lists 43 brand-name drugs, and that is it. You cannot get these drugs directly through TrumpRx, but you can print a coupon that may work at the pharmacy counter to buy your medications in cash.

That means patients cannot use insurance, and they have to pay entirely out of pocket. In many cases, when you try to use TrumpRx, patients are redirected to pharmaceutical companies existing direct to customer sales or discount programs.

And these patient assistant programs offered directly by manufacturers, they can be helpful, but they existed long before TrumpRx, and yet, he is taking credit for them.

Also, existing platforms have long offered cash paid discount options for patients, including GoodRx and Cost Plus Drugs.

In fact, when you look at TrumpRx coupon, it is not only identical to one from GoodRx, they both have the same identifiers. And last week, President Trump rolled out TrumpRx and claimed, and I quote, This launch represents the largest reduction in prescription drug prices in history by many, many times, and it is not even close.

Secretary Kennedy then claimed TrumpRx would deliver, quote, the lowest prices in the

developed world. And so I wanted to ask Ms. Reilly, yes or no, are these claims accurate? Please answer yes or no.

Ms. Reilly. Which claim? I just want to be clear.

Mr. Veasey. This launch represents the largest reduction in prescription drug prices in history many, many, many times, and it is not even close.

Ms. Reilly. I have not verified that fact.

Mr. Veasey. Okay. Thank you.

Professor Sachs, do you agree?

Ms. Sachs. I also don't have any information to verify that.

Mr. Veasey. Thank you very much.

There is also a key difference between TrumpRx and other discount sites. GoodRx allows patients to compare prices across multiple pharmacies and across both brand-name and generic drugs.

That comparison function is critical because generic drugs account for nearly 90 percent of the prescriptions filled in the U.S. They are often dramatically cheaper than their brand-name equivalents.

TrumpRx does not offer that comparison, and, in fact, does not include generics at all despite the fact that half of the drugs listed have cheaper generics available elsewhere.

Let me give you an example. Tikosyn, a drug that is used to treat irregular heartbeats, its listed price is $672. Trump listed it for $336. That is half price, so that sounds good, right?

Well, the generic equivalent is actually available through Cost Plus Drugs for $10. You can likely get it through your insurer for cheaper too.

Professor Sachs, is it your understanding that paying out-of-pocket for a brand-name prescription drug through TrumpRx for a drug that has a cheaper generic alternative may, in fact, cost consumers more money? Yes or no?

Ms. Sachs. I agree with that, and I fear consumers will not understand that when they are using the platform.

Mr. Veasey. Thank you very much.

Mr. Murphy, do you agree?

Mr. Murphy. We certainly hope that there is more information out there.

Mr. Veasey. We still cannot hear you.

Mr. Murphy. Can you hear me now?

Mr. Veasey. There you go.

Mr. Murphy. Yes, Mr. Veasey, we certainly hope that patients have a full complement of information available to them about where they can get cheaper medicines.

Mr. Veasey. Thank you very much.

And many of you may be asking yourself why are there only 43 drugs listed on TrumpRx, and I can tell you that these drugs are limited to those made by manufacturers that enter into a so-called, most favorite Nation, or MFN, pricing agreements with the Trump administration.

And as we have already gone over today, these are back-door deals that have zero insight into the information.

So, Mr. Crowley, in your February 9th letter to Congress, you warn that MFN agreements could eviscerate the innovation pipeline, that cause the engine of American biotech innovation grind to a halt.

And that is on top of the trillions of dollars Republicans have stolen from Americans while inducing chaos at HHS.

And so, there are a lot of concepts of this plan, but I think America still -- there are lot of answers when it comes to these drug prices.

Thank you, Mr. Chairman. I yield back.

Mr. Griffith. The gentleman yields back.

Now I recognize Mrs. Miller-Meeks for her 5 minutes.

Before she goes, I want to say that we will recess after that for votes, and then as soon as Ms. DeGette and I can get back here and somebody is here to ask questions, we will start again.

Mrs. Miller-Meeks?

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

As both a physician, a military veteran, and a Member of Congress, I approach this issue from two perspectives: one clinical and one policy-driven.

From my clinical experience, I have sat across from patients who have skipped doses, split pills, or simply went without the medications they needed. After searching through every dataset I could, couldn't find a less expensive medication to substitute, so they went without medications because they simply could not afford them.

This should never happen in the United States of America.

From a policy standpoint, I believe that for too long the conversation around drug pricing has been overly simplistic, often pointing fingers at just one part of the system.

Manufacturers blame PBMs, PBMs blame manufacturers, insurance blame both, but the patients are paying the price. The underlying fact is, patients don't particularly care which part of the supply chain is to blame. They just know they are paying too much, all the while seeing their premiums rise every year.

Mr. Gelfand, from the ERISA employer plan perspective, you represent the businesses that directly bear the cost of rising premiums for millions of workers, about 130 million in the United States.

My bill, the Lower Healthcare Premiums for All Americans Act is designed to increase transparency, strengthen competition, and reduce the hidden cost drivers in the system.

From your vantage point, would these reforms translate into lower costs for

employer-sponsored plans and ultimately lower premiums for American workers and their families?

Mr. Gelfand. Thank you, Congresswoman. We absolutely believe that more competition and more transparency are key to getting healthcare costs under control.

Mrs. Miller-Meeks. Thank you very much.

As I noted in our last subcommittee hearing, the largest PBMs have created PBM GPOs, two of which are based overseas.

Ms. Boliver, to the best of your knowledge, can you help this committee understand if medical GPOs are based in the United States -- if medical GPOs are based in the United States -- why are several PBM GPOs based overseas?

Ms. Boliver. Yes, I can confirm that the GPOs that belong to my association are all U.S.-based. I am afraid I cannot speak to business practices of other associations.

Mrs. Miller-Meeks. Are medical GPOs retaining fees in the commercial market like PBM GPOs do?

Ms. Boliver. No. We work solely in the provider market and Part B space.

Mrs. Miller-Meeks. Mr. Marin, as I have said since my time as Iowa's public health director and even in Congress, sunlight is the best disinfectant. So I will ask you directly, why do several of your affiliate companies -- CVS Health and OptumRx -- operate PBM GPOs based overseas?

And are medical GPOs retaining fees in the commercial market like PBM GPOs appear to do? And as we have heard, no, they are not.

Mr. Marin. Well, importantly, Congresswoman -- and, again, thank you for your passion on these issues. I know it goes back to your time in Iowa -- all GPOs -- all rebates, whether it is PBM rebates or GPO rebates now must be passed through, thanks to the law that you passed 2 weeks ago.

Mrs. Miller-Meeks. Thank you.

Ms. Reilly and/or Mr. Crowley, should there be -- the NIH provides research support to academic institutions to advance basic biomedical research, and I have seen in this in real time in

academic medicine when I was on faculty.

If patented inventions arise from that research, the Bayh-Dole Act allows the private industry to negotiate licensing agreements to further research and develop the invention into new medicine to benefit patients, to take that entity private.

Should there be a reasonable mechanism, such as royalty or revenue-sharing arrangements, such as there are with venture capital investing in a new innovative company, to ensure that the public sees a return on its investment once a product is commercially successful?

And if not, what alternative approach would you propose to balance strong, private sector incentives with responsible stewardship of taxpayer dollars that are used to initiate research?

Ms. Reilly. Thank you for the question. And there actually are requirements that if a university license a invention, that they have patented, to a pharmaceutical company and that pharmaceutical company is able to produce a tangible asset, a medicine from it, that that company would then owe royalties back to the university, and that the universities retains the royalties for that, which there are requirements in terms of how those royalty dollars get spent.

They have to share some with the inventors and use the rest of it to reinvest back into research and development.

Mrs. Miller-Meeks. Could it not be reinvested back in the NIH?

Ms. Reilly. Potentially. I think, you know, there are other ideas in terms of how that money could be used, but I think the system, I would say today, Bayh-Dole was transformational when it was passed in 1980, because it created a system that does not exist and hadn't existed anywhere else in the world, which is cooperative research between academia, industry, and government.

And I would say, we should hold that system and ensure that we keep it --

Mrs. Miller-Meeks. My time is over. If I can, I would like to submit a letter from Representative French Hill for the record.

Mr. Griffith. Date? What is the date on the letter?

Mrs. Miller-Meeks. February 11th.

Mr. Griffith. Date of February 11th, letter from French Hill, without objection, so ordered.

[The information follows:]

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

Mr. Griffith. All right. With that, the committee will stand in recess until Ms. DeGette and I return and somebody else, whoever it might be.

[Recess.]

[1:05 p.m.]

Mr. Griffith. The committee will come to order. We will once again begin questioning, and I now recognize the gentlelady from Texas, Ms. Fletcher.

Mrs. Fletcher. Thank you, Mr. Chairman, and thank you to the witnesses here today. This has been an informative and helpful hearing, and I am sorry I won't have time to ask follow-up questions to each of you, but I do think, like everyone else, I will end up submitting some for the record. But we have covered a lot of ground in the hearing today.

Ms. Sachs and Ms. Reilly, you both touched on the importance of research and the research ecosystem between the government, academia, and the private sector in your testimony this morning.

And Mr. Crowley, you raised, in your written testimony, the importance of protecting scientific research and integrity in general and at the FDA in particular.

This cannot be understated. I represent a lot of people who work in this space, and it is critical that we do not undermine and destroy this ecosystem, whether with unchecked, cavalier decisions made by un- or under-informed actors in the administration, like we saw last year, or with bad policy decisions coming out of this body.

Ms. Reilly, you also testified that there are some perverse incentives in the system today, and I want to touch on some incentives of concern at this moment. Understanding your role as a representative of a trade association here, I will ask my questions with that in mind.

But, Mr. Chairman, I want to support Ranking Member DeGette's request to have the member companies appear before this committee as well because these are issues of real concern.

Ms. Reilly, have any of your members expressed concerns that FDA approvals, or meetings about approvals, or review, or milestones, have been conditioned upon holding those meetings at properties owned by President Trump or his family members.

Ms. Reilly. No.

Mrs. Fletcher. You have not heard that?

Ms. Reilly. I have not heard that, no.

Mrs. Fletcher. So none of your members have notified you of any such requests for meetings with the FDA to be held at Trump properties?

Ms. Reilly. No.

Mrs. Fletcher. Or for representatives of pharmaceutical companies to stay at Trump properties when meeting with the FDA?

Ms. Reilly. No.

Mrs. Fletcher. Okay. Same thing for requests that member companies participate in private events at Mar-a-Lago?

Ms. Reilly. Not to my knowledge, no.

Mrs. Fletcher. So you are not aware of those requests being made at all?

Ms. Reilly. No.

Mrs. Fletcher. Okay. So making sure that I understand you correctly, none of your members have expressed concern to your association that to get meetings with the FDA or information about approvals, it is being suggested to them, or instructed, that they stay at Trump hotels, hold review meetings at Trump hotels, or attend events at Mar-a-Lago or elsewhere, or even discuss whether those proposals are being made to them?

Ms. Reilly. No, not to my knowledge at all.

Mrs. Fletcher. Are your members prohibited from raising those kinds of concerns with the association?

Ms. Reilly. I don't know whether they would be prohibited from it, but they haven't, so.

Mrs. Fletcher. It is not your understanding that the antitrust laws would prohibit the companies that are members of your association from having those conversations in your meetings?

Ms. Reilly. No. I mean, I am a lawyer, I am not an antitrust lawyer, but I don't know that

that would be an antitrust concern. Usually it is about the conduct of how they do business.

Mrs. Fletcher. Yeah. Well, and I think this is an important question. But you would agree with me, would you not, that the FDA or any government agency conditioning participation in the provision of information, relating to the regulatory approvals of any kind, on staying at properties or meeting at properties owned by the President of the United States and his family members, and that even the suggestion of doing so would be illegal, unethical, and unacceptable?

Ms. Reilly. Certainly probably unethical, yes. I don't know if it is illegal, but unethical, yes.

Mrs. Fletcher. Mr. Crowley, I have the same questions for you about your members. I can go through them all again, or are you aware of any of those conversations from your member companies?

Mr. Crowley. No, Congresswoman, I have never heard that before.

Mrs. Fletcher. Okay. Thank you. I will submit some additional questions for you for the record.

I do want to follow up on, with the little time I have left, follow up on some of the questions from Mr. Veasey, when he was discussing TrumpRx before our break. And.

I think that we have covered a lot about what TrumpRx is, so I have just a minute to ask a question about it. I will say, I am confused as to why the pharmaceutical companies that fought against the Medicare Drug Negotiation Program and were actively objecting to efforts that Congress was undertaking to negotiate drug prices are now willing to negotiate drug prices with the Trump administration.

But, Ms. Sachs, I just want to ask you, with the 30 seconds or so we have left, which program will provide more cost savings to consumers, TrumpRx or the Medicare Drug Negotiation Program?

Ms. Sachs. This administration has said that in the most recent round of drug price negotiations, they have saved about $12 billion, net, for consumers, as compared to previous cycles -- or what would have otherwise been paid -- excuse me -- it is going to be $12 million. And

so, I am happy to get additional citations and share them.

The short version of this is that the drug price negotiation program is saving costs for Americans out of pocket, and a much broader range of Americans, than the small number of products we are seeing on TrumpRx so far.

Mrs. Fletcher. Okay. Thank you. I have gone over my time. Mr. Chairman, I yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentleman from Oregon, Mr. Bentz, for his 5 minutes.

Mr. Bentz. Thank you, Mr. Chair. Thank all of you for being here.

Ms. Sachs, I read your incredibly impressive bio, and I note that it says, her work analyzes problems of innovation and access to new healthcare technologies, primarily pharmaceuticals.

I am extremely interested in what part artificial intelligence might help us play in analyzing situations just like the one we are engaged in today.

And I have been on my phone going through questions that I might ask using the systems that we now have available for that purpose, but you are an expert in this space.

Do you anticipate that artificial intelligence is going to provide us -- or maybe already does -- provide us with ways of looking at this entire space, this pharmaceutical space, and determining where best to focus our attention?

Ms. Sachs. So it is my understanding that companies all across the supply chain are using various AI tools already, but there is many different ways in which it can appear.

So we know that FDA has approved -- at least the last time I looked -- well over 1,000 AI-enabled medical devices, thinking about the potential benefits they might have for patients.

I have certainly read that companies are using AI to think about streamlining clinical trial enrollment and things like that. So there is certainly a wide range of applications that it could have.

I am not an AI scientist. I am not sure what is the best place to focus that investment --

Mr. Bentz. So we were described in Congress as a bunch of people on horseback trying to catch up with a moving Lamborghini to install a seatbelt. That is how they described our efforts to understand artificial intelligence.

So that is why I am asking you, do you anticipate that we in Congress can use these tools to better refine and understand that which is going on in this space?

Because to me, a lawyer who represented a small hospital years ago, I don't know anything about this. I have to rely upon experts like you now to tell us the best tools available to determine the best thing to do.

So I am asking, what would you recommend we do when it comes to using these new AI tools, as Congress, to sort this out?

Ms. Sachs. Well, one important thing for this committee to consider is oversight and transparency. And so getting some of these contracts between the various entities in the supply chain, sometimes these are voluminous, right? There is lots of different provisions in them, and it is possible -- I certainly can't speak to specific technologies -- but it is very possible that advanced technologies, like the ones you suggest, could be helpful in having this committee look at the vast amounts of data and contracts that you are hoping to get from some of these companies?

Mr. Bentz. I had a physician call me about 4 weeks ago. We spent 2 hours a day for 4 days going over his analysis, using new AI tools to determine how many -- how much money could be saved in a hospital.

To protect the innocent or not so innocent, I won't mention which one, but I will just say that at the end of the 4 days, he had determined that he thought he could reduce the number of tests being given in the hospital by half, just because of analytical assistance provided by AI.

And the $50 million that has been given in the Big Beautiful Bill to small, rural areas to try to use innovation to transform, which I think is another word for innovation, what would you recommend we focus upon?

I can look at the WHO six pillars of healthcare, but tell me, what should we focus on?

Ms. Sachs. Well, I appreciate that this Congress instructed CMS certain factors to consider in issuing those awards, and CMS issued a very detailed funding notice and took applications, and lots of States have proposed lots of different things that are tailored to their rural health populations.

One concern I have, and maybe one thing to keep an eye on, is the potential for an AI arms race, right, between providers and insurers, how is AI being used to, as you said, streamline care, avoid unnecessary tests, but also maybe deny care or in the prior authorization process.

Mr. Bentz. Well, I am aware of that, and thank you for calling that out. I am going to shift over to Mr. Hoey for just a moment.

I was speaking to the Murray Pharmacy out in little Condon, Oregon, where -- one of the small areas I represent in my rather large district -- and they were hoping we would do something.

I mean, they are third generation, working -- I couldn't believe the amount of work that they were doing as they were talking to me. I couldn't believe it. They were moving as fast as they could possibly go. And it was apparent that they were in deep trouble.

What would you recommend that we do here to try to help these small pharmacies? I know the whole day we have been focusing on this. What is the best thing we could do?

Mr. Hoey. Yes, the Murrays are members of our organization, Ann and her family. And it is a vital question -- how can we better support these pharmacies that are in rural deserts.

One provision could be a fair cost plus. Right now, pharmacies are paid, in the Medicare program, 80 percent of the time, the prescriptions they dispense are paid below their cost, plus a minimal dispensing fee -- 80 percent of the time. The Medicare program is putting pharmacies out of business.

The legislation that was passed last week, it will help. It doesn't go into effect until 2029 though. We need CMS to implement it much faster. We also need to take away the perverse incentives of PBMs with patient-steering --

Mr. Bentz. And I understand that.

Mr. Hoey. Thank you.

Mr. Bentz. We are out of time.

I yield back, Mr. Chair.

Mr. Griffith. Thank you. The gentleman yields back.

I now recognize the gentleman from Massachusetts, Mr. Auchincloss, for his 5 minutes.

Mr. Auchincloss. Thank you, Chair.

I would invite my friend from Oregon to join the Pharmacists Fight Back Act, which I have introduced, a bipartisan bill that would do cost plus reimbursement for our small pharmacies, as well as cracking down on specialty steering and other PBM abuses.

So we will send it over to the gentleman's office. Had 60 cosponsors last Congress.

I appreciate the thoughtful and substantive testimony from all of you here today. However, I don't think right now the moment calls for us to have nine witnesses. We need one witness, and that individual needs to be Commissioner Makary of the FDA, whose incompetence and whose poor stewardship of the Food and Drug Administration is undermining the world's gold standard biomedical regulator.

Just today, CBER's rejection of mRNA vaccine, which overruled career scientists at the Agency, builds upon a pattern of replacing safety and efficacy with fear and favor.

The commissioner's national priority voucher is unethical, unwise, and illegal, and they have refused, now after three letters from me, to respond to any of the questions or assertions I have put forward.

One former FDA commissioner told me that FDA has hemorrhaged 20 years of competence and credibility in just the last one, and yet, we don't have a hearing.

When is this committee going to do its constitutional job and bring Commissioner Makary here and ask him under oath what he is doing to one of the agencies that keeps Americans safe?

In my district, I represent a lot of people who invent medicines, as well as a lot of people who consume medicines, and they are consistently frustrated by a false choice that is put forward between innovation and access.

We can have both, with strong intellectual property laws, with insurance design that lowers, or limits, copays, and with negotiations that prioritize value as opposed to rebates.

We can have both, world leading biomedical innovation, and we can have virtually no cost exposure at the pharmacy counter.

To that end, I will be putting forward a Request for Proposal from all nine of you that seeks to establish two pillars for drug pricing legislation: one pillar being access and affordability, and the other pillar being innovation and manufacturing.

And I would request that, rather than pack into 5 minutes questions from all of you, that you would all respond in writing within 14 days to the Request for Proposal.

Would you all be willing to do that?

[No verbal response.]

Mr. Auchincloss. Thank you. I will give you a flavor of some of the things I will be putting forward. Under access, for example, prior authorization reform that prioritizes transparency, timeliness, and an appeals process with electronic-based prior authorization.

Under an affordability agenda, extending the $2,000 out-of-pocket caps into the commercial markets. The $2,000 out-of-pocket caps under Part D have been an important way to ensure that patients don't face high out-of-pocket caps.

I understand that in the commercial markets, that $2,000 copay cap may need to be paired with a ban on pharma-funded coupons so that they cannot undercut negotiations that the PBMs do do for leverage.

Under innovation, I will note that a July 2025 Meta analysis of peer-reviewed studies found that, quote, After the IRA's implementation of the pill penalty, larger manufacturers prioritized

incremental innovations, or lower-risk therapies, while smaller firms faced challenges in their R&D pipelines.

The President's misguided GLOBE and GUARD models would further distort and add rebates into a value chain that already has too many of them, and I welcome thoughts from all nine of you about how we can induce more R&D in this country and deliver more cures faster, because we know that the Chinese have not just caught up, but may actually be outpacing us at this point, and I think American patients want access to new medicines first.

Also welcome thoughts on clinical trial reform. Mr. Crowley, you spoke, I think, very cogently about institutional review boards. We are also interested in ways that we can better integrate electronic health records at more sites of care so that people can enroll faster.

Faster, better, cheaper clinical trials is a win across the board.

And then finally on manufacturing, would welcome proposals about how to improve recently introduced bipartisan legislation, the Drug Shortage Prevention and Mitigation Act, which basically envisions a CMS pay-for-performance model for quality and reliability, to also incentivize more made-in-America manufacturing.

I think we need to reindustrialize much of our biomedical backbone, and CMS has a role to play in its pay-for-performance program.

I appreciate your willingness all to engage on this with written responses, and I look forward to releasing the RFP. Thank you.

Mr. Griffith. And the gentleman yields back.

I now recognize the gentleman from Texas, Mr. Crenshaw, for his 5 minutes of questioning.

Mr. Crenshaw. Thank you, Mr. Chairman. Thank you all for being here.

I want to talk about something pretty specific, the biosimilar interchangeability that is in statute, and it is a statutory distinction, and it does seem to a lot of us that it is an extra hurdle for biosimilars to come to market, and of course, you know, it is the generic version of biologics and

cheaper for the patient.

But this distinction requires that extra statutory hurdle -- or extra regulatory hurdle. You know, I want to see if you have conflicting views on this.

Mr. Murphy, in your view, does updating these somewhat outdated distinctions, like biosimilar interchangeability, strengthen competition without undermining safety, and what would eliminating that extra statutory distinction do for uptake, affordability, and investment in biosimilars?

Mr. Murphy. Yeah, thank you, Mr. Crenshaw, for that question. We have long supported removing the statutory distinction, as has the Food and Drug Administration publicly called for the same earlier last year.

I think what we hear from our manufacturing partners is that anything to reduce the cost and regulatory complexity of biosimilar development is going to be a net benefit for patients.

And I think that ultimately, we will see more investment across the biosimilar pipeline. I would note, just for the record, that, you know, we looked at 118 biologics that lose exclusivity over the next 10 years in the United States.

Only 12 of them are currently being developed for biosimilar competition, and that transcends just the regulatory barriers, but this would be a huge step forward, and as you noted the Biosimilar Red Tape Elimination Act, which is cosponsored in this committee by Mr. Landsman and Mr. Pfluger, would be a step in the right direction.

Oh, I am sorry. I looked over there for you.

Mr. Crenshaw. And, Mr. Crowley, what do you think about that? What would eliminating that extra distinction do for uptake, affordability, and investment in biosimilars?

Mr. Crowley. Yeah, Congressman, I agree with Mr. Murphy, we need more biosimilars, and we need to see where the barriers are to getting these biosimilars to market and to patients.

Interchangeability is an important concept. There are many biologics where you can simply

do laboratory testing or some basic bridging studies in animals and approve them without lengthy, expensive, political studies.

There are some medicines, though, including the one I developed for the rare disease, Pompe, where you can make a biosimilar, same amino acid sequence, same protein, same number of carbohydrates that are essential to get into the muscles of these sick kids.

But if one of those carbohydrates is slightly off, you lose 90 percent of the effectiveness of getting into muscle. Ultimately, that needs to be a science-driven decision of where you need more extensive clinical studies.

Mr. Crenshaw. Okay.

Mr. Crowley. But whatever we can do to break down barriers I support.

Mr. Crenshaw. You need to be specific in your wording. You said you agree with breaking down the barriers, but, you know, we are talking specifically about removing this particular hurdle.

So I mean, Mr. Murphy, you heard that particular concern. I mean, so how does Congress design a system where we can meet in the middle there?

Mr. Murphy. So, Mr. Crenshaw, the current legislation that is being considered by this committee actually has the authority for FDA to order additional studies should it determine, in consultation with the manufacturer and the referenced listed drug product, that that additional step is necessary.

But as a predicate matter, it aligns the U.S. regulatory system with all of our peer countries to have a base level of singular approval.

Mr. Crenshaw. Yeah. And sticking with this theme, Ms. Reilly, for advanced therapies, whether it is biologics, Celgene therapies, talking about regulatory modernization, what role does that play in ensuring that innovation really translate to patient access?

Ms. Reilly. Well, I think, you know, the important pillars that exist in our country, you know, absolutely need to remain if we are going to continue the kind of innovation that we have been

responsible for since -- you know, over the last many decades.

I worry that some of the new therapies that are coming to market or that are being studied, Celgene, some of the more expensive therapies, if there is not a market to be able to sell into, if we don't have a transparent regulatory body that we can rely on for predictable advice, then we risk, candidly, this science, much of which is in its infancy stages.

So I think continuing to have strong intellectual property protection so that when companies do make the big bets to bring a therapy to market, that there is a reward at the end, and that companies can rely on that.

And then having a regulatory body that has the capability -- the scientific capability -- to evaluate those products, and then a market to sell those products into where patients can get access to them at an affordable price.

Mr. Crenshaw. I appreciate that and agree, you know, Big Pharma companies, they are going to be fine when these kind of extra stringent, whether it is regulations or price controls, get put on them. They are just going to invest in things that aren't risky.

And that is a problem, and it leaves behind, you know, these small portions of patients that need cures.

I yield back. Thank you.

Mr. Griffith. The gentleman yields back. I now recognize the gentleman from Ohio, Mr. Landsman, for his 5 minutes of questioning.

Mr. Landsman. Thank you, Mr. Chair, and the ranking member, to all of you for being here. It has been a long day, so I appreciate the patience as we had to go vote.

I want to get into, you know, the goal, I think we collectively have, which is -- or at least our assignment -- is to increase care and reduce costs.

And we have to make policy decisions, we do, as lawmakers, you all do, or your companies that you represent, have to make these policy decisions. So I want to take on two. One has to do

with, on the profit side, where you invest those profits.

So, Ms. Reilly, the number I have, in terms of Big Pharma and how much they have -- they pulled down in profits last year, it was around $130 billion. Does that sound accurate to you?

Ms. Reilly. I don't have the number off the top of my head.

Mr. Landsman. Fair enough. I wasn't trying to get you on that one. I just -- of that, you can -- after expenses, you got $130 billion across these pharmaceutical companies. You can invest those dollars in innovation R&D, employees, lowering costs -- investing in pricing, which is a strategy, or the, you know, it goes up to the investors and the stock buybacks and the dividends.

Our understanding is that of the $130 billion made last year, $84 billion, or the majority, the vast majority of the profits went up, not down, right? So it went to the shareholders and to pay out dividends.

That is a decision in terms of how to invest these additional resources, and I am curious, now that more and more Americans are struggling to pay their bills in general, in particular, their healthcare bills, are there discussions around changing that percentage so that the vast majority, or a greater majority of the profits, are investing in pricing?

Ms. Reilly. I would say this: Our industry is the most R&D-intensive industry in the world. We reinvest 30 percent of our profits back into research and development. That is, by far and away, more than anyone else.

Mr. Landsman. Yeah, but the challenge is, pharma gets this sort of reputation, well, we have to invest in innovation -- and I agree -- so that you can move more and more of these drugs to generics, and it can be cheaper, and we are saving lives, 100 percent, but that means 70 percent -- even at 30 percent, 70 percent of those profits are going elsewhere, not in R&D, not -- so, you know, how do we get the investments in lowering prices and R&D to be the vast majority, 80, 90 percent?

Ms. Reilly. Well, you know, when individuals decide to invest with our companies, there is

an expectation for return on investment, just as there is for any for-profit company. But our companies are different in the sense that 90 percent of what we do and what we put into the FDA clinical trial process fails.

So they are investing with an acknowledgement that more than likely, we are going to fail than 90 percent of the time. So when we do succeed --

Mr. Landsman. It has been a great return on investment. I mean, every, you know -- folks are --

Ms. Reilly. Ninety percent of biotech companies make no profit, 90 percent.

Mr. Landsman. But the investors always get paid. You know, I don't know how many investors have walked away empty-handed. Most of the folks, you know, who are investing are walking away with enormous amounts of money.

And I agree, there is risks, but it does -- it is challenging when you are seeing $85- of the $130 billion go up, not to patients or to lower prices.

Ms. Reilly. Well, you know, 77 percent of our investors are institutional investors that represent firefighters, policemen, teachers, and the like. So I think they do expect a return on their investment for their retirement and lots of other things.

You know, as I said, we are a risk-intensive industry. It is almost like playing the lottery. When people are betting money on our success, there is an expectation for a return --

Mr. Landsman. I wish -- it is a good line. I wish that the firefighters and folks in pensions were reaping the benefits of what Wall Street is, you know, pursuing in terms of profit. But it is just not -- it is just not --

Ms. Reilly. They do in their 401(k). I am happy to provide --

Mr. Landsman. For sure. They are not the big winners.

Ms. Sachs, or Professor Sachs, pharmaceutical companies set prices, and they can lower prices by investing more and more with the profits in prices?

Ms. Sachs. They set the list price, yes.

Mr. Landsman. Yeah. I am not allowed to ask another question even though I had a question about biosimilars which is on our end, because there is a ton that we have to do to reduce the cost, and bringing the biosimilars to the market faster is one of those things.

So hopefully, everyone jumps on board. This one thing that you all agree on, I think, is the biosimilars work. So thank you and I yield back.

Mr. Griffith. The gentleman yields back.

I remind everybody that if you have questions for the record, you can always ask.

I now recognize the gentlelady of Florida, Mrs. Cammack, for her 5 minutes.

Mrs. Cammack. I appreciate it. Thank you, Mr. Chairman, and thank you to our witnesses. I know it has been a long day. Our apologies for votes getting stuck in the middle.

But I want to start with the folks back home. So families and employers keep asking us the same question: Why does healthcare cost so much, and why is the system so stinking hard to navigate.

Now, if you can't explain the bill, you can't defend the system. And if you look at the facts, it really presents us this:

Between 2021 and 2024, median launch prices for new drugs more than doubled, and in a single year, over a thousand existing drugs saw price increases averaging more than 30 percent. That is far above inflation.

Now, patients didn't see their paychecks double, workers did not see their premiums fall, and so what we have right now looks a lot less like healthcare and a lot more like sick care, a system that is waiting for people to be in crisis before it acts. This is a maintenance, rather than prevention, system.

And as we all know, particularly you all before us today, know that crisis is more expensive than prevention.

When a patient is handed a bill that they don't understand, they don't care which entity in the supply chain is responsible. They just know that they are paying more. And so, costs being layered across manufacturing, distribution, and contracts are something that patients never see.

When prices rise and revenues grow, families still struggle and people begin to question whether the system is prioritizing patients or profits.

So we should be able to do two things at once. We should give companies the certainty that they need to invest and innovate here in the United States, but we also need to be delivering real tangible, visible savings, and affordability and accessibility to patients.

So I think that this discussion is very timely. I am going to start with you, Mr. Davis.

Three companies control the majority of drug distribution in the United States, and many are vertically integrated to control each phase in the prescription drug supply chain from manufacturer to pharmacy.

Does consolidating the prescription drug industry lower prices for patients, yes or no?

Mr. Davis. I am sorry. Does the consolidation lower the prices?

Mrs. Cammack. Correct.

Mr. Davis. It has the potential to, yes.

Mrs. Cammack. Okay. So respectfully, your own industry report projects that the big three will generate $871 billion, with a B, in revenue just this year, and that is after 4 straight years of double-digital growth.

So if this is potentially saving patients money, why are your revenues growing so fast and where are patients seeing the savings?

Mr. Davis. So thank you for the question. I would say there are a couple aspects to your question. One, we are the only sector in distribution that I am aware of where actually our cost of the goods sold, the amount that we actually sell downstream for, is more money than the revenue that we get. Right?

So it is an unusual one where we are actually in a position that we are actually selling a product for less than we are purchasing it for from a wholesaler -- excuse me -- from a manufacturer. Manufacturers set the list price.

Mrs. Cammack. Okay. But let's get back to the patients because this is ultimately about patients, right? So --

Mr. Davis. Absolutely.

Mrs. Cammack. -- if your industry has spent $16 billion acquiring physician management companies -- basically buying doctors, right -- where is the savings for the patients?

Mr. Davis. So in the ability to have the doctor treat -- we are not buying physician practices. With respect, what we are doing is, we are purchasing organizations that are providing the business support to physician practices in places like oncology and gastroenterology, and in eye care as well. And these are, again, three of our 36 members that are in this diversified business area.

But one of the things that we hear from those provider groups when they are actually partnering -- and in certain instances they are being purchased by the wholesaler. In others, the wholesaler is either a majority or minority investor. They are not the complete owner of the vertically integrated MSO, as they are called, management service organizations -- but to be clear, they are not purchasing the physician practice.

Mrs. Cammack. Well, and my time is running short, so I have a whole litany of questions that I am going to submit in writing for the record for you.

Right now, I want to jump to Mr. Gelfand. Did I say that right? My apologies if I botched that.

You represent the employers who sponsor the health coverage for millions of workers, the lion's share of those that are covered and insured. So when distribution gets more concentrated, in your opinion, do premiums go up or down for workers?

Mr. Gelfand. Yeah, we have heard this story before. It took place when private equity

started to buy up physician groups and --

Mrs. Cammack. Kind of what Mr. Davis was just talking about?

Mr. Gelfand. -- it let to the surprise billing crisis that Congress had to ultimately intervene.

Mrs. Cammack. So who, in the end, with my remaining 15 seconds, who captures the, quote/unquote, savings from all of this consolidation?

Mr. Gelfand. It does not appear to be working families.

Mrs. Cammack. Thank you for driving that point home. I know my time has expired. I have a number of questions I will submit for the record.

Thank you, Mr. Chairman. I yield.

Mr. Griffith. The gentlelady yields back. I now recognize Mr. Rulli for his 5 minutes.

Mr. Rulli. Thank you, Chairman. My question is for Mr. Marin.

President Trump recently launched TrumpRx, a revolutionary platform bringing price transparency and competition back to the drug market.

My constituents tell me every day how often they dread going to the pharmacy because they never know what kind of price they are going to pay at the counter. It always changes, and then you have the brand-name versus the off brand-name.

So I guess my first question to you, sir, would be, how have your members reacted to the transparent pricing of brand names on the TrumpRx?

Mr. Marin. Thanks for the question. Look, the PBM industry is all about transparency. We are enhancing it for our customers everyday, for employers. The bill that Congress just passed a couple weeks ago takes it to a whole other level. We are happy with that.

We support and applaud the mission of the administration's goal with TrumpRx. Obviously the details will matter.

Mr. Rulli. Well, and that is what we are looking forward to, you know, working out all those ruffles and those bumps in the roads.

How will letting patients and employers see the compare prices affect the wider pharmaceutical industry? Is there going to be a big impact, or what is your opinion on that?

Mr. Marin. From TrumpRx?

Mr. Rulli. Uh-huh.

Mr. Marin. I think that is yet to be seen, Congressman, but, you know, obviously, we applaud new entrants, more choices, more competition.

Mr. Rulli. Do you have any final words that you would like to, as far as the TrumpRx program goes, that you would like to see happen or maybe pulled back a little bit? What is your opinion on that?

Mr. Marin. No, we look forward to being a partner with the administration as it unfolds the initiative, and we know that at least a couple of our members are participating.

Mr. Rulli. Well, we look forward to any kind of emails that you want to send to our office on suggestions to make it a better product.

And with that, chairman, I will yield my time.

Mr. Griffith. Thank you. The gentleman yields back.

I now recognize the gentlelady from Indiana, Mrs. Houchin, for her 5 minutes of questioning.

Mrs. Houchin. Thank you, Mr. Chairman. Thank you to the witnesses for coming before the committee today.

This is our second hearing in a series examining the overall affordability of healthcare. A huge part of that conversation is the cost of prescription drugs for patients.

For millions of Americans, especially seniors and those living in rural communities, like my hometown in southern Indiana, the price of medications can determine whether people stay healthy or go without care altogether.

Today, Americans are paying more out of pocket for their medications than ever before. At the same time, we are seeing growing concerns about drug shortages that threaten patient access

and provider stability.

A central part of that solution, as I have advocated for since coming to Congress, is transparency. We have heard consistently from independent pharmacies about the challenges they face navigating complex reimbursement and contracting structures, particularly when they are not always negotiating directly.

Many independent pharmacies rely on pharmacy services, administrative organizations to collectively negotiate PBM contracts, manage administrative requirements, and secure network participation on their behalf.

And while that aggregation can create efficiencies and bargaining leverage, it can also create distance between a pharmacy and the contract terms that ultimately govern the reimbursement and performance obligations.

My first question is for Mr. Hoey. Since PSAOs negotiate PBM contracts on behalf of many of the members that you represent, do your members always have a line of sight into the terms that they are agreeing to on behalf of your members?

Mr. Hoey. Yeah, thank you for the question. No, not always. The PSAOs represent several thousand pharmacies, and they don't always know what those terms are. Those terms are sometimes limited to their sight -- they don't have sight into them because of restrictions in that contracting process, where a PBM may say, you cannot reveal these terms.

One important thing with those PSAO contracts to add is that when you get a group of independently owned businesses together, while it does create some efficiencies in the administration, it doesn't create much leverage in the negotiation of those contracts.

The contracts are still basically "take it or leave it." If you leave it, I am going to take a third of your business away from your pharmacy. If you take it, you are going to take my terms, says the PBM, not your terms.

Mrs. Houchin. I come from a line of pharmacists. Some of them are community

pharmacists. Some work for national chains -- or have worked for.

But when I am in my district, I do hear from community pharmacists and independent pharmacists that are concerned about the way that these -- the drugs that they are being required to dispense often cost them money out of pocket when they can get a reduced price -- a price can get a reduced price at the CVS across the street.

How is that? I still haven't been able to have anybody really explain the math to me about how if I go to one of your pharmacists, it might cost of the pharmacist $7 out of pocket to dispense that drug to me, but yet the pharmacy, the independent -- or the chain pharmacy across the street makes a profit? How does that work?

Mr. Hoey. Well, you specifically mentioned CVS as the example. CVS is one of the vertically owned pharmacies that is part of the Aetna-Caremark vertical integration of family -- family of businesses. So they can manipulate things by putting money from one pocket into the other.

They also set the terms, the reimbursement terms, for that independent pharmacy. So the competitor is setting the reimbursement terms for the small business. And so they can say, Competitor, you are going to lose money on that, and I am going to make money on that.

And I am also going to set the terms for the patient too, so it can appear the patient is paying less, but in reality, that employer may be paying even more for that drug at the chain pharmacy.

Mrs. Houchin. One of the things that we hear is that because of their larger size, they can often negotiate cheaper prices, and that is why.

I want to turn to Mr. Marin just to ask a question about, How does the PBM who is negotiating the rates between these entities, how do they make a profit?

Mr. Marin. Moving forward now, it is a bona fide fee --

Mrs. Houchin. And it went --

Mr. Marin. -- because all rebates have to be passed through now. So it is going to be up to the employers who receive the pass-through to determine how best to use those dollars.

Mrs. Houchin. I would like to turn to Ms. Reilly about the differences and how it has changed from a rebate structure to a fee structure, and what that has done to cost?

RPTR SINKFIELD

EDTR ROSEN

[1:44 p.m.]

Ms. Reilly. Yes, I think increasingly as employers and others have gotten wise about the fact that rebates were increasing, they demanded access to those rebates. So PBM shifted to a new strategy. They set up offshore PBM GPOs and started collecting more and more money from fees that were not transparent to the employer, not transparent to the taxpayer.

Today, about two-thirds of the revenue and profits that PBMs get are from their specialty pharmacy and from the fees that they collect, in part, because, again, like the laws that were just passed, they are requiring rebates to be passed through. So, they have shaped shifted and moved on to a new path.

I appreciate the conversation. I am sure we will talk more. Thank you to the witnesses. And I definitely want to engage on this issue further. Thank you, Mr. Chairman.

Mr. Griffith. Thank you very much. The gentlelady yields back.

I now recognize the gentleman from New York, Mr. Langworthy, for his 5 minutes of questions.

Mr. Langworthy. Thank you very much, Mr. Chairman. A consistent theme across the prescription drug supply chain is that every major actor blames another major actor for high prices, opaque practices, and rising patient cost sharing. Manufacturers point to PBMs and rebate structures. PBMs point to manufacturer list prices. Pharmacy cite reimbursement practices. Wholesalers reference contracting dynamics. And plan sponsors often claim they lack visibility into any of it.

While there may be some truth somewhere in the middle of all of this, that does not change this reality, is that Congress, employers, and patients still do not have access to transactional level price data needed to determine where excess costs are accruing, who benefits, and who ultimately

bears the burden of that. And if we do not understand the accounting of our healthcare system, we cannot answer a basic question: Why is healthcare so much more expensive than it was 10 or 15 years ago? And that is what I think many of us here in Congress struggle with, with that opaqueness across the entirety.

But with that, Mr. Gelfand, given the competing claims that we have heard across the prescription supply chain, how does the lack of transaction level pricing data limit Congress' ability to determine whether the costs are truly occurring? And without that level of visibility, how can we distinguish between reforms that would meaningfully lower costs for patients and those that merely shift the cost around the board among stakeholders here today?

Mr. Gelfand. Thank you, Congressman. You know, we strongly believe we have got to open the books. In no other part of the economy is it considered acceptable that all of the prices for goods are essentially kept a secret. Employers can only solve the problems that we can clearly see and identify. So, that is why we so strongly supported the reforms that passed last week and why we hope for more transparency throughout the healthcare system and especially throughout the opaque parts of the drug supply chain.

Mr. Langworthy. Well, thank you. And I think that is exactly why better data has to come first. It is time for all the stakeholders across the healthcare system to flip their cards over and be honest, and so we have an honest discussion as to why the cost of healthcare in this country have exploded the way they have.

Mr. Gelfand, would requiring clear price disclosures for patients and giving plan sponsors full visibility into what they are actually paying for prescription drugs help address the lack of transparency that we have now?

Mr. Gelfand. Absolutely. That is why we strongly support the Patients Deserve Price Tags Act. Not only with that bill for the first time shine a light on the black box of drug prices, but it would also guarantee that employers could actually see their own claims data, which today they

oftentimes do not. And it would even require that patients get real timely bills, which today you can go to the hospital you may not get a bill for ages, years. You get a bill later. Price tags we think would lower drug costs. It would certainly enable us to lower drug costs for the people who work for us and their families.

Mr. Langworthy. Well, thank you. I think price transparency is an absolute prerequisite to identifying which policy reforms will actually reduce costs rather than simply just shuffle them across the entire system and continue on this endless cycle.

Pivoting here to prescription drug data, Mr. Marin, under the Transparency and Coverage Rule, health plans and PBMs are already required to disclose machine readable prescription drug pricing data. However, those prescription drug reporting requirements were never meaningfully enforced under the Biden administration.

From your perspective, how would access to this level of transaction level pricing data change Congress' ability to conduct meaningful oversight of the prescription drug supply chain and determine where those excess costs are actually accruing?

Mr. Marin. I think it would be significant, Congressman. And I think -- you know, the only thing I will say about transparency, given the law that was passed just 2 weeks ago and the reams of information that we will be now providing to clients and to the government, is that it should be applied across the supply chain, right. But yeah, to your question, I think that would be a massive improvement, and we would love to help you think it through.

Mr. Langworthy. Price transparency must come across a prescription drug supply chain if it needs to come into our hospitals and to all of our providers so that the American people can exactly see where these dollars are going.

Mr. Marin. The information that we have to provide, Congressman, now is to the clients and the government is drug by drug, claim by claim, pharmacy by pharmacy. It is robust.

Mr. Langworthy. Hear, hear. It is clear that if we want to lower prescription drug cost for

patients, we must ensure that real transparency exist across the supply chain and enforce these rules that are on the books now. And I appreciate all the witnesses for their time and being with us here today. And with that, I yield back, Mr. Chairman.

Mr. Griffith. The gentleman yields back. I now recognize Mr. Mullin of California for his 5 minutes.

Mr. Mullin. Thank you, Mr. Chair. And thank you to our witnesses for being here today. As we turn our attention to the prescription drug supply chain, Congress has taken important steps in recent years to address high drug prices, such as Medicare drug price negotiation, a language recently signed into law, increasing PBM transparency, and cracking down on unfair practices. But it is vital that we find a balance to enable patient access to affordable drugs while ensuring the U.S. continues to lead the world in developing innovative therapies and cures.

I am very proud to represent California's 15th Congressional District, the birthplace of biotechnology and my hometown of south San Francisco. From well-established companies to scrappy startups and everything in between, my constituents are pushing scientific boundaries in the hope of developing the next drug that could change a patient's life -- your mother, your uncle, your sister, your child -- for this lifesaving work both in my district and across the country to translate into real outcomes for patients. Each step in the supply chain must function effectively and reliably.

One area that I am concerned about is the current staffing cuts in leadership and turnover at the FDA. Without a dependable and science-based drug review process, there could be dire consequences for the future of U.S. R&D and innovation. And delays in this process can quite literally spell the difference between life and death for some patients.

So, Mr. Crowley, are timely interactions with the FDA important for your member companies to get products to patients? And I think I know the answer to this question, but --

Mr. Crowley. The answer, Congressman, is yes.

Mr. Mullin. Well, that is the speediest answer I have gotten in my 3 years here.

Mr. Murphy, since the staffing cuts, have you heard of the potential for these cuts to undermine upcoming review capacity and timelines for drug reviews? Give us kind of the lay of the land there.

Mr. Murphy. Yes, so there has obviously been a lot of historical support that is no longer with the agency, and that has created a lot of concern amongst the members. We have been surveying our members. We have not yet seen delays. But we understand that the members have a lot of angst because they realize it could take time to matriculate through the system given how the FDA practices work.

Mr. Mullin. So, thank you for affirming what I suspected. I appreciate the answers. It is important that the Federal Government meet the needs of patients by ensuring the FDA is a reliable partner for drug review and approval.

Another area I want to touch on is rare diseases. Despite nearly one in 10 Americans having a rare disease, only about 5 percent of the thousands of rare diseases have an FDA approved treatment. Given how small some of the patient populations are for these diseases, evolving therapies requires innovative thinking and policies to ensure patients have solutions that they can turn to.

So, Mr. Crowley, if you can just break down the factors that companies must consider when developing a rare disease therapy so my colleagues can understand the complexity with that.

Mr. Crowley. It is. Thank you, Congressman. If you can hear me. Hello? There we go. So, it is very complex, Congressman. So, when I ran a biotechnology company, when we looked at any one of the 10,000-plus rare diseases, obviously, enormous unmet need, suffering, death. So, you certainly had the need out there. We would look at the patient population size. We would look at what is the natural history of the disease. Are there ways to do clinical studies faster and better? Are there biomarkers that could accelerate the research process as well? So, that is all in the science innovation side.

We look at the manufacturing. How complex is it? Biotech -- small-emerging biotech companies where 70 percent of our medicines originate, our business model is not to build manufacturing plants. We rely on our partners, large companies. We will rely on contract manufacturers. We don't have enough capacity in the United States. That is a huge limitation on making medicine. So, that is an important factor.

And, of course, we look at the regulatory environment. What is the pathway? Is it certain? Is it predictable? Are their known end points? Do the regulators have experience? Do you have regulators, enough regulators, scientific medical reviewers at the FDA? So, it is an incredibly complex problem set to go through all of that. And at the end of the day, we also need to make sure that our patents are protected for our inventions, and we need to make sure that we are paid innovations and inventions as well. That is the lifeblood that continues to provide capital so we can research the next disease.

Mr. Mullin. I appreciate that very much. Thank you all for being here. Thank you for the answers.

The biotech industry is a prime example of America's indispensable role in advancing science and healthcare. Breakthroughs that were once satellite science-fiction are becoming reality. But to sustain this momentum, we must continue to incentivize domestic research and development while ensuring that patients can afford the life-changing therapies developed here in the United States. And with that, thank you all, I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentleman from Georgia, Mr. Allen.

Mr. Allen. Thank you, Chair Griffith, for letting me waive on to this important hearing. I want to thank all of the witnesses, and I want to thank what you do for the American people. And it is amazing the progress we have made in research and development.

The rising cost of prescription drugs has been causing significant burdens for millions of

American patients and seniors. For far too long, Americans have had to choose between much-needed prescriptions and household expenses. That is why I am glad we are having this hearing today to explore solutions to lower the cost of care for Americans.

Now, I had a really great experience. My pharmacist on Monday -- before I left to come -- usually, he is there to complain to me, but he came and he says, Well, can I speak to you a minute, and I am going to give you some good news. He said, Eliquis, which is a drug that is used -- he said the price is substantially down. And he said, Furthermore, we are making a little better than a dollar when we sell it. And before, we were losing a lot of money selling it. The only problem is my accountant says revenues are down because drug prices are going down. But I said, you know, our profits are up. He said, yeah, profits are up. So, that is something that corporate America can learn, I guess. But that was good to get that good news. And I told him I would spread that.

Now, Mr. Gelfand, insurers and PBMs often go against doctors' orders by requiring patients to step through multiple medications before they can receive their originally prescribed medicine. This happens in the part D market, the commercial market, and now in the Medicare advantage market for part D drugs.

Would the Safe Step Act, which I introduced earlier this Congress, help hold insurers accountable for increasing the use of step therapy leading to nonadherence and access issues? Mr. Gelfand?

Mr. Gelfand. Thank you, Mr. Congressman. We believe that reform to step therapy does make sense. And, for instance, it should all be electronic. It should not be faxed on old fax machines, and it should be timely when patients need an answer. But we also believe the medical management is important.

Mr. Allen. Okay. Thank you.

Ms. Reilly, in other countries, patients have access to fewer innovative medicines. In the

U.S., 85 percent of new medicines are reimbursed, versus only 24 percent in Australia and 21 percent in Canada. In the U.K., uptake of new cancer medicines is only about 8 percent of what it is in the U.S.

Patients in other countries also wait longer for their medicines on average. OECD countries have access to 18 percent of new medicines launched within one year of global first launch. U.S. patients have access to 78 percent of new medicines within one year.

But I still hear from my constituents that they have all kinds of hoops to jump through before they can access these groundbreaking therapies.

It is critical that patients are able to access the medicines they need to treat their health conditions. Could you please explain what the biggest barriers to patient access in the U.S. are, and what can be done to address those barriers?

Ms. Reilly. Yes, thank you for the question. I think the first step is today there are 1,453 medicines that last year got excluded from the Big Three PBM formularies. If you look back 10 or 15 years ago, when a medicine was approved, it typically was available to patients. That is no longer the case. Large numbers of medicines get excluded.

Once you have actually gotten on the formulary, it doesn't necessarily mean you are going to get access to the medicine. If you are in Medicare part D and you are prescribed a brand-new medicine, half the time that medicine is going to get denied originally. You are going to have to jump through a hoop, prior authorization, some form of utilization management. And in the commercial market it is 70 percent.

So yes, your patients, or your constituents, are experiencing a lot of what we are seeing, which is the hurdles continue to go up. We also now have high deductible health plans. Eighty million Americans are in a high-deductible health plan, which means, when they go to the pharmacy because they have met their deductible, their insurance company and PBM are charging them the full list price of the medicine, not the negotiated price. As a result, the PBMs and insurance

companies are making money every time that prescription is written.

In fact, the GAO looked at this in part D and found of the seven -- of the hundred most rebated medicines in 79 cases, 79 out of a hundred, the PBM and insurance company made 400 percent more than what the patient was paying for the medicine.

So this is not a system that is sustainable. We have a great system in America. Patients do have availability of medicines, but the hurdles that get put in place are significant.

Mr. Allen. Well, I thank you. My time is up, but I will say this: I am going to do everything I can in my time here to correct this problem. This should not be going on in our country.

Mr. Griffith. The gentleman yields back.

I now recognize the gentlelady from Virginia, Ms. McClellan, for her 5 minutes.

Ms. McClellan. Thank you, Chairman Griffith, and Ranking Member DeGette for holding this very timely hearing.

For many Americans, approaching the pharmacy counter today feels like falling into a financial sinkhole. Within the past year, approximately one in five adults opted not to fill their prescriptions because they were just too expensive. In Virginia, that burden is even heavier with one in four adults skipping essential medicines. Seniors, parents, and individuals with chronic illnesses or disabilities have to make impossible choices between paying for household necessities and the medications that grow more expensive with every refill.

Women in particular shoulder a heavier burden for prescription drugs. In 2024, women spent nearly 30 percent more out of pocket on prescription drugs than men. Whether it is recurring costs for birth control, menopause treatments, or medications for conditions like endometriosis and post-partum depression, women pay a prescription pink tax simply to maintain our health.

At the same time, rather than working to reduce the drug prices women and families are facing, congressional Republicans have driven up healthcare costs and undermined efforts to lower

prescription drug spending. The big, ugly law, including provisions to weaken Medicare's ability to negotiate the price of essential drugs like Keytruda, which is often used to treat cervical cancer, endometrial, and breast cancers.

According to the Congressional Budget Office, this change leaves pharmaceutical companies with almost 9 billion in additional revenue over the next decade. Congressional Republicans have put profits ahead of the health and financial security of women and families.

Meanwhile, Congressional Democrats' Inflation Reduction Act, which empowered Medicare and negotiate for lower drug prices has also saved the taxpayers and seniors on Medicare billions. Democrats will continue to fight to advance policies that actually lower prescription drug prices to bring relief to Americans' prescription costs and pocketbooks.

Ms. Sachs, following the congressional Republicans' weakening of Medicare Drug Price Negotiation Program, which expanded the program's orphan drug exemption and delayed the selection of blockbuster drugs like Keytruda, what avenues exist to strengthen the program and continue to bring savings to the American people?

Ms. Sachs. There are already bills introduced in this committee that would do things like extend the benefits of the Drug Price Negotiation Program to the commercial market, extend the inflation rebates from the IRA to the commercial market. And there is a number of proposals that would do things like consider the selection of drugs.

So, as you noted, right, whether some of these products are orphan drugs that should truly be exempted, as Keytruda made $31.7 billion last year alone. Whether that is the type of drugs that drafters really had in mind when trying to expand this orphan exemption, there is a whole range of ways the program could be expanded to more patients or strengthened even within the Medicare program.

Ms. McClellan. And Ms. Sachs, your testimony discussed incorporating international reference pricing into the Medicare Drug Price Negotiation Program. Can you expand on how this

approach would work alongside the existing negotiating framework and the potential benefits challenges?

Ms. Sachs. So, international reference pricing seems to have bipartisan interest. It was included in H.R. 3, which is a previous drug price negotiation bill, and then it is obviously a topic of interest for the Presidential administration as well.

There is a lot of ways to think about including international reference pricing elements within negotiation if that is desired. So, for example, it could be one of the factors that Congress instructs CMS to consider as part of the negotiation. It could be a tool to think about selecting drugs in the first place.

Where is the price disparity the largest? It could feature into the setting of some of the initial offers. What is the ceiling as defined under the law? So, there is no one way to do it and to incorporate it, but lots of choices.

Ms. McClellan. Okay. And, Ms. Reilly, less than a minute. What actions can pharmaceutical companies take to ensure critical medications, including those for birth control and menopause remain affordable for women and families?

Ms. Reilly. Thank you for the question. You are right. Our companies, many of whom are in the women's health space and pride themselves on insuring that we have access to women whether it is looking for contraceptives, IVF care, post menopause, and the new menopause drugs that have come to market, you know, our companies operate in a system where we do face competition. And that is a good thing because it does help to drive down costs in the system and make those medicines more affordable.

As you know, in the Affordable Care Act, contraception is available for patients at zero cost, which I think has expanded access in that space. And we would love to work with you to ensure that all women's healthcare products are available and affordable to patients.

Ms. McClellan. Thank you. I look forward to that, and I yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentlelady from California, Ms. Matsui, for 5 minutes of questioning.

Ms. Matsui. Thank you very much, Mr. Chairman. And I want to thank the witnesses for being here today. I know it has been a long day. I will be quick.

We are one of the richest countries in the history of the world. But today, one in five adults say they haven't filled a prescription from their doctor because they can't afford it. One in five. It is unconscionable really, and I am glad we are here to discuss solutions.

I would like to share a story from one of my constituents. She is a small businessowner in my district. And after struggling with opioid addiction, she is 11 years sober. Now, for 11 years, she has relied on buprenorphine to help her stay in recovery. But recently her insurer, Aetna and PBM, CVS Caremark tried to cut her off from a typical medication and switch her to Suboxone. That is not only an entirely different medication, it is one that this constituent has already tried and failed. And despite her doctors explaining she needed buprenorphine, not Suboxone, the appeal was denied. She was forced to pay $700 at the pharmacy counter to get her prescribed medication.

Mr. Marin, how can the PBMs you represent possibly justify keeping someone from their lifesaving medication given the very real possibility of relapse?

Mr. Marin. Congresswoman, thanks for the question. It is a terrible story, and I would like to follow up with you and your staff to better understand the details of what happened and see what we can do about it. But look, PBM's mission is to keep drug prices lower. They do that. The market is very competitive, and employers choose the right fit for them.

Ms. Matsui. Okay. Is that your answer? Is that right? Okay. But this is common sense. I don't think we need all the facts to agree that people need to stay on their medication, assisted treatment to avoid a life-altering, even life-destroying relapse into substance use disorder. And, unfortunately, this is a pattern too many patients are familiar with, being blocked from their lifesaving medications because the insurer of PBM thinks they know better than the doctor itself.

And I am really sorry, and I welcome your comments. And I hope that you will answer them. And that is it. Thank you very much.

Mr. Griffith. Thank you. The gentlelady yields back.

Seeing no other Congress people showing up to ask questions, we will move forward. And I would ask unanimous consent to insert in the record the documents included on the staff hearing, documents listed without objection, it is so ordered.

[The information follows:]

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

Mr. Griffith. I would like to thank all of our witnesses -- it has been a long day -- for being here today, and thank you for giving us your time.

As we have said repeatedly, many members will have additional written questions for you. I will remind members that they have 10 business days to submit questions for the record. And I would ask the witnesses to respond to those questions promptly. Members should submit their questions by the close of business on Thursday, February 26. And without objection, the subcommittee hearing is adjourned.

[Whereupon, at 2:09 p.m., the subcommittee was adjourned.]