



Feb. 11, 2026

House Energy and Commerce Health Subcommittee Holds Hearing on the Prescription Drug Supply Chain

Overview:

Today, the House Energy and Commerce Health Subcommittee held a hearing on lowering health care costs throughout the prescription drug supply chain. The hearing featured nine witnesses representing all major aspects of the supply chain, including manufacturers and biotechnology companies, pharmacy benefit managers (PBMs), health care group purchasing organizations (GPOs), pharmaceutical wholesalers, employer groups, community pharmacists and academia. While Republicans, Democrats, and witnesses discussed varying opinions on the role of each actor in the supply chain, there was striking agreement between committee leaders of both parties to pursue additional oversight into the details of the Trump administration's Most-Favored-Nation non-public drug pricing arrangements with 16 manufacturers. Committee members also discussed the recently unveiled [TrumpRx](#) drug pricing platform, which was designed to provide MFN prices to cash-paying patients. There was partisan disagreement on the ability of TrumpRx to lower prices, with Democrats alluding to the website's repackaging of existing discount programs and lack of lower-cost generics and Republicans applauding the administration's efforts to bring down drug prices.

Nonetheless, an overwhelming majority of questions were posed towards PBM business practices, despite the passage of [significant PBM reform legislation](#) last week. While lawmakers and witnesses celebrated the law's transparency and reporting provisions and required full pass-through of rebates to plan sponsors, many argued that significant action could still be taken to reform other PBM business practices. This was most apparent in discussions of vertical PBM integration and consolidation as well as the practice of spread pricing. The focus of these questions alludes to the fact that congressional appetite for additional PBM reform is unsatisfied. Committee members also reengaged with [prior efforts to restrict health insurer practices](#) including prior authorizations and the potential use of artificial intelligence (AI) in coverage decisions. Legislation including the Lower Healthcare Premiums for All Americans Act ([H.R. 6703](#)), Pharmacists Fight Back Act ([H.R. 6609](#)), and Safe Step Act ([H.R. 5509](#)) were offered as actionable reforms to PBM and health insurer practices.

The hearing also touched on several components of the supply chain that have faced less scrutiny in recent hearings but are expected to face further congressional attention in the near future. This includes pharmaceutical wholesalers, who faced criticism similar to that of PBMs over vertical integration and consolidation. Legislators and witnesses also delineated the differences between medical GPOs, which do not directly purchase drugs and are largely based in the United States, and the foreign-based rebate GPOs owned by large PBMs. Based on these lines of questioning, policy proposals to influence rebate GPOs are expected as Congress shifts its PBM reform priorities. Pharmacy Services Administrative Organizations (PSAOs) also received attention over the nature of their contracting practices, in which thousands of pharmacies are grouped into single contracts with

limited flexibility. Several lawmakers and witnesses also spoke to the frontline benefits provided by community and independent pharmacies, lauding the fact that pharmacists are often the most accessible health care practitioners and medication experts for America's rural and underserved patients.

- 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
- Douglas Hoey, Chief Executive Officer, National Community Pharmacists Association
- Rachel E. Sachs, Professor of Law, Washington University in St. Louis

Committee Leadership:

- Health Subcommittee Chair Morgan Griffith (R-VA)
- Health Subcommittee Vice Chair Diana Harshbarger (R-TN)
- Subcommittee Ranking Member Diana DeGette (D-CO)
- Full Committee Chair Brett Guthrie (R-KY)
- Full Committee Ranking Member Frank Pallone (D-NJ)

Question & Answer Highlights:

Chair Griffith – Mr. Marin, if you support competition, should the FTC break up the three largest PBMs that control 80% of the market?

Mr. Marin – The answer is simply no. Ours is a highly competitive market with 73 full service PBMs. They offer different services, markets, etc.

Chair Griffith – Do PBMs approach manufacturers with threats to shift to other manufacturers that offer higher list prices on covered drugs?

Mr. Marin – That would be an outlier. We negotiate lower prices and provide significant value. I think more competition is better.

Chair Griffith – Mr. Crowley, you said that insurer denial policies can cause harm and suffering. If we look at insurers as fiduciaries who intentionally delay treatment, they should be liable for that damage. Your thoughts?

Mr. Crowley – We support anything that advances patient protection and gets medicine.

Chair Griffith - Mr. Gelfand, you said the same thing about PBMs as fiduciaries. Can you explain?

Mr. Gelfand – A fiduciary has the responsibility to do the right things for patients and control costs. You'll still have tough choices but be confident that decisions are not profit-motivated.

Chair Griffith – Specialty drug costs have skyrocketed in recent years. Can you explain what a specialty drug is?

Mr. Gelfand – It's not possible to explain; it is a made-up definition. There is variance among the big three PBMs on what a specialty drug is. My definition is "an expensive drug."

Ranking Member DeGette – Last fall, President Trump threatened manufacturers with tariffs. Now, 16 companies have made secret deals with the White House. Ms. Reilly, what did your member companies agree to?

Ms. Reilly – As a trade association, we don't have individual knowledge of what our companies do. There are also antitrust regulations.

RM DeGette – Mr. Crowley, thank you for sharing your story and shoutout of 21st Century Cures. How important is it to your member companies and your family that the US fosters a vibrant science-driven research ecosystem.

Mr. Crowley – It's vitally important when you think about all that goes in to producing new drugs. Research from the NIH is what helps us lead the world in biotech innovation.

RM DeGette – How many fewer grants did NIH award last year compared to an annual average?

Ms. Sachs – About 24% less. Funding fewer grants is likely to lead to fewer treatments. Almost 100% of new drugs have NIH funding underpinning them.

RM DeGette – How has the research community reacted to the fact that federal research grants now need to be approved by political appointees?

Ms. Sachs – We've heard that scientists are self-censoring in hopes of securing approval. Other countries are also allocating funding in hopes of luring American scientists. The FDA has also lost hundreds of employees, including about 90% of senior leadership.

RM DeGette – is it fair to say that FDA staff turnover harms industry confidence and thus investment in new treatments.

Mr. Crowley – We need a modernized and reformed FDA. The core of that is leadership and staff. The changes have been very difficult, but I'm hopeful that the FDA will return to gold standard research.

Chair Guthrie – Employers cover 168 million lives. What is preventing employers from negotiating fair deals with PBMs?

Mr. Gelfand – For a free market to work, there has to be access to information and rules of the road. That, for the most part, did not exist until legislation was passed last week.

Chair Guthrie – Are people not competing against each other?

Mr. Gelfand – One of the challenges we've had, which last week's legislation addressed, is that intermediaries who represent the patients are paid by both sides of the negotiation. ERIC has multiple member companies with over 1 million employees whose negotiation strategies were denied by the big three PBMs.

Chair Guthrie – Mr. Davis, the largest wholesalers are Fortune 15 companies and affect 90% of prescription drugs. Why is this better for the system?

Mr. Davis – It's important to distinguish the degree of diversification among leading wholesalers. They are creating working relationships with pharmacies and providers; they do not own provider groups and are building out diversified business practices in response to concerns about access to affordable drugs.

Chair Guthrie – Mr. Hoey, you represent the independent pharmacists. How does last week's bill benefit community pharmacists?

Mr. Hoey – The reasonable and relevant contract provision is most beneficial. Medicare Part D is the worst payer that is putting pharmacies out of business. This provision gives us a chance to stay afloat.

Ranking Member Pallone – I want to follow up on the secret agreements. But we also have this quack HHS Secretary. Nobody will want to work for FDA as long as he's in charge. Why would you invest today with this FDA? How are Congress and the American people supposed to know that the MFN agreements will benefit patients if we don't know what's in them? Are we just supposed to trust the administration?

Ms. Reilly – I think you'll have to take their word for it.

RM Pallone – Mr. Chairman, would you be willing to work with us to gather more information into the secretive MFN deals?

Chair Griffith – Yes, I'm happy to work with you to get as much information as we can. I'm a big believer in transparency.

RM Pallone – In order to determine if these agreements save money, don't you need additional information?

Ms. Sachs – Yes, and we know almost no public information about these deals, such as agreed upon prices and what drugs are covered, as well as the governments enforcement ability. I don't think we have enough info to know if these deals will save money. Half of the drugs available on TrumpRx have lower cost generic alternatives.

Vice Chair Diana Harshbarger – Drug affordability remains a top concern. Too many prescription drugs carry high price tags. When a patient comes to my pharmacy, they have to decide between medicine or groceries. Yet overall prescription drug price growth has remained below the rate of

inflation. How have pharmaceutical prices actually grown over time? Can you explain what the real cost drivers are?

Ms. Reilly – We are the only part of the system with costs that go down over time, with competition from branded and generic medications. We continue to represent 14% of healthcare spending. At the top of the list, hospital spending has continued to rise with half of every dollar spent. This is driven by consolidation, where I have sympathy for payers. There are no generic hospitals or doctors.

Vice Chair Harshbarger – Large employers see firsthand how patent thickets can influence high drug prices. How would requiring drug manufacturers to make consistent disclosures to FDA and the patent office help curb abuse of patent thickets without limiting innovation?

Mr. Gelfand – The FDA PTO legislation would cut down on litigation and allow biosimilars to enter the market, but inconsistent filings have allowed branded manufacturers to delay the entrance of biosimilars to the market. Improving those disclosures will improve the patent life but ensure they can't be staggered.

Vice Chair Harshbarger – Mr. Hoey, small town pharmacies join GPOs to lower acquisition costs. You testified that PBM-owned GPOs keep manufacturer rebates before they even reach the pharmacy. What is the difference between these GPOs?

Mr. Hoey – The offshore GPOs allow PBMs to shift rebates and launder fees. Employers are now extorted for fees to Switzerland and Ireland.

Rep. Debbie Dingell (D-MI) – Members all agree that we have a real problem with drug pricing. In particular, PBMs are a major player in the supply chain. We did commonsense reforms in the FY 2026 Labor-HHS funding bill, but there is more work to do. Mr. Hoey, for some medicines, why is it cheaper to purchase out-of-pocket than with insurance, as TrumpRx claims. Why do PBMs tell pharmacies that they can't offer the same?

Mr. Hoey - When PBMs process prescriptions, they add spread pricing. If they can route that through the PBM, they inflate costs for the consumer. This leads insured drugs to be more expensive than cash. PBMs don't want pharmacists discussing costs with patients because they want to route higher-priced prescriptions. Legislation was passed to ban gag clauses which has been helpful.

Rep. Dingell – How can Congress address the perverse incentives that PBMs use to steer patients towards more expensive drugs.

Mr. Hoey – One thing we can do is provide access to the net price of drugs. PBMs extort fees from the list price, but the net price allows pharmacies to help provide lower drug costs.

Rep. Gus Bilirakis – Our committee has prioritized policies to improve drug development. Congress created processes to spur orphan drug development, but challenges exist in covering cell and gene therapies. How can we encourage investment in these therapies without breaking patients' wallets?

Mr. Crowley – There are more than 10,000 known rare diseases that affect 10% of Americans. Only several hundred have cures, so we need to focus on innovation, reducing complexities in clinical trials, reducing the costs of development, bringing certainty and predictability to the regulatory process, and ensuring access to these medicines. Cell and gene therapies have the potential to cure rare diseases, and we need novel payment methods.

Rep. Bilirakis – We must ensure patients have access. Current PBM incentives could lead to PBMs prioritizing drugs with high rebates. Can you elaborate on how these incentives affect formulary coverage for low-cost generics and biosimilars.

Mr. Murphy – We see significant drop off in formulary coverage of generic medicines. One of the most important things is recognizing that as the exclusivity period ends, generic coverage should be prioritized. At the plan level we talk about more rebates, but we want to get to the point where a patient is paying less.

Rep. Nanette Barragan (D-CA) – The three largest PBMs control 80% of the market, correct?

Mr. Marin – Yes.

Rep. Barragan – The top six PBMs process 90% of prescriptions in the US. What does this do to consumers?

Mr. Gelfand – For every supply chain entity that adds fees and margins, that adds costs for consumers.

Rep. Barragan – The three biggest PBMs made millions for marking up drugs for cancer, HIV, and other conditions. It's hard enough for patients with these conditions, now they have to deal with this. Mr. Hoey, thank you for the work that pharmacists do. We're also looking into the effects of vertical integration. Can you explain what this means in terms of pricing?

Mr. Hoey – Patients are essentially controlled throughout their healthcare journey. For example. CVS pharmacies are probably the smallest part of the company compared to Aetna or CVS Caremark. Patient choices are compromised every step of the way.

Rep. Buddy Carter (R-GA) – Mr. Marin, PCMA claims that your industry saves consumers billions, but I know this isn't true. FTC found the big three PBMs to be charging enormous markups. In 2022, a large share of drugs were marked up over 1,000%. Can you stand by PCMA's claim that PBMs make health care more affordable?

Mr. Marin – Yes. I understand the concerns about independent pharmacies. PBMs are reimbursing at higher rates and moving to cost plus contracts, but there is still more work to do.

Rep. Carter – The FTC recently reached a settlement with ExpressScripts that requires them to bring transparency into its business practices. Will PCMA commit to adopting the requirements of this settlement into a standard business practice for all of its member companies?

Mr. Marin – There's a lot of good stuff in there, but there are many good things the industry is moving towards on its own, such as enhanced transparency, \$0 drugs with no patient cost sharing, and cost-plus contracts.

Rep. Carter – What about GPOs based in foreign countries? Are you going to try to bring them back?

Mr. Marin – Those are strategic business decisions that I'd want to ask individual companies to answer.

Rep. Kim Schrier (D-WA) – Epi Pens can cost over \$600 out of pocket. I want to call on all manufacturers to drop the price. Turning to this administration's war on MRNA vaccines. Mr. Crowley, what impact does the denial of Moderna's breakthrough flu vaccine have on innovation?

Mr. Crowley – We share your belief in the importance of vaccines. I can't comment on specific companies, but we are concerned with shifting standards. We need predictability from regulatory bodies and acceptance of vaccines.

Rep. Schrier – Turning to the Vaccine Injury Compensation Program (VICP), RFK spent decades undermining trust in vaccines. RFK has also made millions recruiting people to sue vaccine manufacturers. Why is it important to have a strong VICP? Are you concerned that autism may be added to the program?

Mr. Crowley – The VICP has worked for decades; anything that threatens the system can be consequential. We have seen no evidence that autism causes vaccines.

Rep. John Joyce (R-PA) – The launch of the Humira biosimilars shows some of the most perverse incentives in pharmaceuticals. Many manufacturers described difficulties getting biosimilars placed on formularies. PBMs prefer the higher cost branded meds because of larger rebates. I've heard from employers whose brokers build in rebate guarantees to pharmaceutical contracts. Can you explain what a rebate guarantee is?

Mr. Marin - PBMs use rebates to lower cost the drugs. They now must be passed through in their entirety to the employer.

Rep. Joyce – Do you feel that the guaranteed rebates play a role in PBMs placing higher priced drugs in favorable tiers?

Mr. Marin – The issue is what employers choose in the design of their program.

Rep. Joyce – Mr. Gelfand, do your member companies use rebate guarantees? Do they lead to lower costs?

Mr. Gelfand – Prior to the passage of PBM reform, a rebate grantee was the only way employers could decide how to choose between different PBMs. We think this will go away thanks to the legislation.

Rep. Joyce – Major wholesalers have purchased large oncology and physician groups over the past few years. How do these acquisitions increase the demand for high-cost drugs?

Mr. Gelfand – Vertical integration does not lead to efficiencies. It leads to higher costs.

Rep. Lori Trahan (D-MA) – Ms. Reilly, what concrete steps should Congress take to strengthen America’s clinical trials and ensure that the US remains a leader in innovative medicine?

Ms. Reilly – The importance of the US leading biomedical research is paramount. China had a multi-decade plan to take over from the US and is having success. We need to improve the FDA clinical trial process, lead on technology, and speed up the process. Strong intellectual property protections are also crucial. The cooperative US ecosystem is why we lead.

Rep. Trahan – How important is it that we invest in platform technologies and strong health data ecosystems?

Mr. Crowley – Preparedness is what it is all about. With mRNA technology, it represented decades of academic work to come together and tackle a public health problem.

Rep. Troy Balderson (R-OH) – How can the FDA modernize trials to expedite early-stage drug development?

Mr. Crowley – We can look to what’s under FDA control, such as requirements to enter clinical studies. Another areas FDA doesn’t control is clinical trials, as we have to work with other entities like hospitals and academic centers with different review boards.

Rep. Balderson – Can you describe the challenges rural pharmacies face when negotiating contracts with PBMs?

Mr. Hoey – PBMs hold all the leverage. If a pharmacy doesn’t sign, it’s take it or leave it. Contracts often pay pharmacies below the cost to acquire a drug. As a result, 5,000 pharmacies have gone out of business in the last four years alone.

Rep. Balderson – Can you explain how the Inflation Reduction Act would alter incentives for generic entry into the market?

Mr. Murphy – Our view is that a free market provides opportunities to bring generics and save money. Parts of the IRA were well intentioned, but provisions like the biosimilar launch delay were done in a way that reduced predictability for manufacturers.

Rep. Marc Veasey (D-TX) – We’ll look into what TrumpRx is or is not. He’s taking credit for existing cash pay discounts and manufacturer direct-buy programs. Are these claims accurate?

Ms. Reilly – I have not verified this.

Ms. Sachs – I don’t have the information to verify that.

Rep. Veasy – TrumpRx does not include generics at all, despite the fact that they are readily available. Is it your understanding that paying out of pocket for higher priced brand drugs with cheaper alternatives may cost consumers money?

Ms. Sachs – Yes, and I fear consumers may not understand this when using the platform.

Mr. Murphy – Yes, we want patients to have a full complement of information.

Rep. Mariannette Miller-Meeks (R-IA) – The Lower Healthcare Premiums for All Americans Act is designed to increase transparency, strengthen competition, and reduce hidden cost drivers. Are these reforms necessary to lower costs for employers?

Mr. Gelfand – We absolutely believe more competition and transparency are paramount.

Rep. Miller-Meeks – Can you help us understand if medical GPOs are based in the United States? Why are PBM GPOs based overseas?

Ms. Bolivar – Yes, my GPOs are. I can't speak to PBMs. We work solely in the provider and Part B space.

Rep. Miller-Meeks – Mr. Marin, why do PBMs operate GPOs overseas?

Mr. Marin – Importantly, all rebates must be passed through thanks to the law you passed.

Rep. Miller-Meeks – If patented inventions arise from NIH research, private industry can negotiate further agreements to research new medications. Should there be a reasonable mechanism such as royalty sharing arrangements to ensure the public sees a return on its investment once profitable?

Ms. Reilly – There are requirements for companies to owe royalties back to universities that license patents to manufacturers. It could also potentially be reinvested to NIH. The Bayh-Dole Act created the cooperative research program we know today.

Rep. Lizzie Fletcher (D-TX) – Have any PhRMA or BIO members expressed concern that FDA review and approvals are being conditioned on holding meetings at properties owned by President Trump.

Ms. Reilly – No, I'm not aware of that. Our members aren't prohibited from raising these concerns.

Mr. Crowley – I am not aware of these concerns.

Rep. Fletcher – Which will provide more cost savings to consumers? IRA negotiations or TrumpRx?

Ms. Sachs – The drug price negotiation is saving out-of-pocket costs for a wider swath of Americans.

Rep. Cliff Bentz (R-OR) – I'm interested in the role of artificial intelligence. Do you anticipate that AI will provide us with ways in determining where to focus our attention on the supply chain

Ms. Sachs – It’s my understanding that many companies already use AI. We know FDA has approved over 1,000 AI-enabled devices. Congress should consider oversight and transparency, getting access to supply chain contracts. Advanced technologies could be used to analyze this data.

Rep. Bentz – In the Rural Health Transformation fund, what would you recommend we focus on?

Ms. Sachs – I appreciate Congress instructing CMS to consider certain factors in these awards. One concern is the potential for an AI arms race between providers and insurers. How is it being used to deny care in the prior authorization process?

Rep. Jake Auchincloss (D-MA) – I introduced the Pharmacists Fight Back Act which would implement cost plus reimbursement and eliminate spread pricing arrangements. We need FDA Commissioner Makary as a witness. I’ll be putting out a request for proposal to your organizations on drug pricing legislation that accounts for access and affordability as well as innovation and manufacturing. This includes prior authorization reform, extending \$2,000 out-of-pocket caps to commercial markets, inducing R&D, clinical trial reform, electronic health record integration, and improving the Drug Shortage Prevention and Mitigation Act to incentivize domestic manufacturing.

Rep. Dan Crenshaw (R-TX) – Biosimilar interchangeability in statute currently requires hurdles. Would updating/removing the interchangeability definition/requirement strengthen competition?

Mr. Murphy – We’ve long supported removing the statutory distinction. Anything that reduces cost and regulatory complexity will benefit patients. The legislation considered by this committee allows the FDA to request additional studies and aligns our systems with other countries.

Rep. Greg Landsman (D-OH) – Of pharma profits, you can invest into innovation, lower costs, or investors. We understand a majority of your profits went to shareholders. Are there discussions around investing profits into pricing?

Ms. Reilly – We reinvest 30% of profits to R&D, more than any other industry. Roughly 90% of drug approvals are denied, meaning investors know they can’t expect profit.

Rep. Kat Cammack (R-FL) – Our system is not focused on prevention. Does consolidating the drug industry lower prices?

Mr. Davis – It has the potential to, yes.

Rep. Cammack – Why are your revenues growing so much, and why aren’t patients seeing the savings?

Mr. Davis – The cost of the goods we provide actually exceeds our revenue. We’re in a position to sell products for less than how we purchase from manufacturers. We’re not buying physician practices either; we’re purchasing organizations that provide support to physicians.

Rep. Michael Rulli (R-OH) – How have your members reacted to the transparent pricing of brand drugs on TrumpRx?

Mr. Marin – The PBM industry supports transparency. We support the administration’s goal with TrumpRx, but the details will matter. I think its impact has yet to be seen. We look forward to partnering with the administration on this.

Rep. Erin Houchin (R-IN) – Pharmacy Service Administrative Organizations (PSAOs) negotiate PBM contracts on behalf of your members. Do your members have insight into the contract terms being negotiated?

Mr. Hoyer – No, not always. PSAOs represent several thousand pharmacies. While grouping entities creates flexibility in administration, it doesn’t create flexibility in contracting.

Rep. Houchin – How can a drug cost independent pharmacies while making a profit for chain pharmacies?

Mr. Hoyer – Because of integration. Integrated companies can set terms for all facets of the system.

Rep. Houchin – Mr. Marin, how does a PBM make a profit?

Mr. Marin – It’s a bona fide fee now. Rebates are passed through.

Ms. Reilly – PBMs now set up offshore GPOs to receive profit through secretive fees rather than rebates.

Rep. Nick Langworthy (R-NY) – How does the lack of transaction level pricing data prevent Congress from determining where the costs are occurring? How can we distinguish meaningful reforms?

Mr. Gelfand – We believe that we have to open the books. No other sector allows prices to be kept secret.

Rep. Langworthy – Would requiring clear price disclosures address the lack of transparency?

Mr. Gelfand – Yes, that’s why we support the Patients Deserve Price Tags Act.

Rep. Kevin Mullin (D-CA) – Have you seen potential for FDA staffing cuts to undermine future drug approvals?

Mr. Murphy – Yes, there is historical support in FDA that no longer assists. We’ve seen concerns from our members about this

Rep. Mullin – Only 5% of rare diseases have FDA approved treatments. What factors must companies consider when developing rare disease drugs?

Mr. Crowley – It is very complex. We look at need, patient population, disease history, biomarkers, complexity of manufacturing. We rely on contract manufacturing and don’t have the capacity in the U.S. We also need to make sure patents are protected.

Rep. Rick Allen (R-GA) – Would the Safe Step Act help hold insurers accountable for prior authorization denials?

Mr. Gelfand – We believe reforms to step therapies make sense. But medical management is also important.

Rep. Jennifer McClellan (D-VA) – After the One Big Beautiful Bill’s Medicare price negotiation orphan drug exclusion, what avenues are left for patients to save costs? How could international reference pricing be included in negotiations?

Ms. Sachs – There are bills that would extend negotiations and inflation rebates to commercial markets. International reference pricing has bipartisan support. There are many ways we can include it, such as one of the factors CMS uses in conducting negotiations or selecting drugs.

Rep. Doris Matsui (D-CA) – How can PBMs justify keeping people from medicine they need to survive?

Mr. Marin – A PBM’s mission is to keep drug prices lower. Employers choose the right fit for them.

Hearing Recording:

- <https://energycommerce.house.gov/events/health-subcommittee-lowering-health-care-costs-for-all-americans-an-examination-of-the-prescription-drug-supply-chain>