Written Statement of Dr. Hugh Chancy, PharmD

United States House Energy and Commerce Subcommittee on Health

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

February 26, 2025

Chairman Guthrie, Ranking Member Pallone, Subcommittee Chairman Carter, Vice Chairman Dunn, Ranking Member DeGette and Members of the Committee:

My name is Hugh Chancy, and I am a pharmacist and co-owner of Chancy Drugs, and former president of the National Community Pharmacists Association. I greatly appreciate the opportunity to share with you my experience as a pharmacist and small business pharmacy owner about how PBMs have negatively impacted my ability to care for my community.

My family has three generations of pharmacists. My parents Hubert and Sue Chancy opened Chancy Drugs in 1966 in Hahira, Georgia. Chancy Drugs has since expanded under me and my brother Bert's leadership, and more recently my son Patrick has also taken on a leadership role. My wife Tina is also a pharmacist who runs our long-term care pharmacies. Chancy Drugs specializes in compounding, specialty packaging, and enhanced clinical services, and employs approximately 100 people across South Georgia.

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

PBMs' Vertical Integration

The top three PBMs control over 80 percent of the market. They not only own or are owned by the insurance company, but the pharmacy and even the physician offices too. Then they steer patients to their own affiliate pharmacies. Many patients who are required to use the PBM-owned mail-order pharmacy receive their medications damaged or do not receive them in a timely manner. Mail-order pharmacy also leads to excessive waste because expensive drugs are auto shipped – even when patients don't need them.

We need to level the pharmacy playing field to protect patients, and the government, from paying too much. Recent reports from the Federal Trade Commission found PBMs are steering patients to use specialty drugs at their affiliated pharmacies, allowing the PBM's to generate more than $7.3 billion in revenue.[1] PBMs are also engaging in anticompetitive tactics like patient

[1] Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers

steering, cost inflation, spread pricing, low pharmacy reimbursements and coercive contracts for non-affiliated pharmacies. These PBM games lead to higher costs for the government, limited patient choices, and increasing pharmacy deserts.[2]

PBM Abuses and Reform Proposals in Medicaid Managed Care and Medicare Part D

PBMs claim they save money for state-funded health plans, like Medicaid managed care, yet numerous reports show something very different: excessive amounts of taxpayer dollars funneled to PBMs. Eliminating spread pricing and moving to transparent cost-based reimbursement saved West Virginia's Medicaid program $54.4 million and North Dakota's Medicaid program $17 million.[3] Kentucky identified $123 million of spread pricing annually, precipitating wholesale changes to their Medicaid pharmacy model. Meanwhile, the Auditor General in Ohio identified more than $224 million of spread pricing. Likewise, Illinois, Virginia, and Maryland have all found egregious sums of spread pricing in their states. So, in fact, PBMs are the cause of significant spending waste.

That's why Congress must pass Medicaid managed care pharmacy payment reform and ban spread pricing by requiring 100% pass-through to the pharmacy of the ingredient cost and the professional dispensing fee,[4] which CBO has scored as saving over $2 billion.[5]

Another pressing concern is that our contracts with PBMs are take-it-or-leave-it. This is especially the case in Medicare Part D. Pharmacists are not able to negotiate better terms in our contracts, in direct opposition to what PBMs have sworn to Congress. Some of the most basic, yet most life-sustaining medications are often under reimbursed, and we are rarely paid for the actual cost to dispense. Georgia's professional dispensing fee for Medicaid patients is $10.63,[6] but it is not unusual for me get to get paid only a nickel, and oftentimes we receive no dispensing fee for Part D patients.

So, in addition to supporting Medicaid managed care reforms, I support the legislative provision requiring "reasonable and relevant" contracts between PBMs and pharmacies in Medicare Part D, quelling PBM exploitation.[7]

Both policies were included in the negotiated health care package at the end of last year. Altogether, the PBM reform policies included in that package save nearly $5 billion and are a

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[2] Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies

[3] NCPA Explainer – State Medicaid Managed Care Reform

[4] Further Continuing Appropriations and Disaster Relief Supplemental Appropriations Act, 2025, p. 436, Section 112. Ensuring Accurate Payments to Pharmacies under Medicaid; p. 449, Section 113. Preventing the use of Abusive Spread Pricing in Medicaid

[5] CBO Cost Estimate on the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act and Certain Provisions of the MEPA Act

[6] Medicaid Prescription Drug Reimbursement Information by State

[7] Further Continuing Appropriations and Disaster Relief Supplemental Appropriations Act, 2025, p. 514, Section 226. Assuring Pharmacy Access and Choice for Medicare Beneficiaries

huge step forward in protecting pharmacies and patients from PBM greed.[8] It is critical these bipartisan, bicameral policies get passed as quickly as possible.

PBMs have fought against any legislation that would require more transparency, let alone changes to their business model. Is it because they are perhaps the only businesses with the power to set prices for their smaller competitors and tell their competitors' customers where to shop? Because of PBMs, thousands of independent pharmacies represented by NCPA have gone out of business over the last decade. And PBMs have not just impacted small pharmacies. Chains are closing at the rate of three a day.[9] If the PBM industry continues to go unchecked, thousands of small pharmacies like Chancy Drugs could go out of business leaving our country with a deficit of care for patients, driving up costs.

Conclusion

I want to conclude my testimony with a personal story that gets to the heart of independent pharmacy. My community was devastated by Hurricane Helene and our town was without power for days. In this time, my pharmacy in Valdosta served as a disaster relief hub to collect and deliver vital supplies like water, baby wipes, formula, and toiletries. Now you tell me... can a PBM do that?

I implore you to take immediate action and pass common-sense legislation to rein in harmful PBM practices to pharmacies and patients alike. We are not asking for favorable treatment, but merely a level playing field. I encourage lawmakers on both sides to continue to work in a bipartisan manner to pass these reforms that save $5 billion. If not, we will see more pharmacy deserts and less access to care. I applaud this committee's bipartisan efforts to shine a light on PBMs, and I am happy to answer any questions.

[8] NCPA Roadmap to PBM Reform
[9] NCPA 2024 Digest, NCPA 2023 Digest