Written Testimony of Kristi Martin
Before the United State House of Representatives Committee on Ways & Weans
Full Committee Hearing on
Protecting Patients and Taxpayers: Cracking Down on Medicare Fraud
April 21, 2026

Chairman Smith, Ranking Member Neal, Members of the Committee, thank you for inviting me to testify on this hearing to examine the prevalence of fraud, waste, and abuse in Medicare and efforts to combat fraud to protect beneficiaries and taxpayers.

I am Kristi Martin, and I am here today as an individual to share my perspective on the most pertinent issues related to this matter and present potential solutions to address them. The views I express today are my own.

I served for more than 10 years in the federal government, including several years at the Centers for Medicare & Medicaid Services. From October 2021 through November 2024, I had the privilege of serving as Chief of Staff and Senior Advisor to the Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS) and Director of the Center for Medicare. In that role, our mission was clear: to serve Medicare beneficiaries, to be responsible stewards of taxpayer dollars, and to ensure the long-term sustainability of the Medicare program. That experience informs the perspective I bring to you today.

Medicare Delivers High-Quality Care for Millions of Americans

Since its enactment in 1965, Medicare has played a central role in improving access to affordable, high-quality health care and strengthening the health and financial security of older Americans and people with disabilities. Today, nearly 70 million Americans rely on Medicare, and the program has fundamentally transformed the delivery of health care for these populations.[1]

Medicare is now the largest purchaser of health care in the United States, accounting for approximately one-fifth of all national health care spending.[2] During my tenure at CMS, one of our core objectives was to ensure that the program delivers value for beneficiaries while serving as a responsible steward of taxpayer dollars—specifically my work focused on making prescription drug prices more affordable for Medicare beneficiaries and lower prescription drug spending in the Medicare program.

Congressional passage of the Inflation Reduction Act enabled CMS to implement the most significant drug pricing reforms since the inception of the Part D program in Medicare. These

[1] U.S. Centers for Medicare & Medicaid Services. (n.d.). *Medicare enrollment dashboard*. https://data.cms.gov/tools/medicare-enrollment-dashboard, as of December 2025
[2] U.S. Centers for Medicare & Medicaid Services. (2024). *National health expenditure fact sheet*. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet

reforms included a $35 monthly cap on insulin cost sharing, elimination of cost sharing for vaccines under Part D, establishment of a $2,100 annual out-of-pocket cap in the Part D program, a comprehensive redesign of the Part D benefit, creation of a new Manufacturer Discount Program, implementation of inflation rebate programs in Medicare Parts B and D, and the launch of the Medicare Drug Price Negotiation Program.

The inflation rebate programs, which require drug manufacturers to pay rebates when prices increase faster than inflation, have generated approximately $1.4 billion in payments to date—funds that are deposited into the Medicare Supplementary Medical Insurance Trust Fund.[3] [4] In addition, the Medicare Drug Price Negotiation Program has produced nearly $19 billion in savings over its first two years by negotiating prices for 25 high-cost brand-name drugs covered under Medicare Part D.[5] [6]

Together, these reforms represent meaningful progress toward lowering prescription drug costs for beneficiaries, reducing prescription drug spending in Medicare, improving the long-term sustainability of the Medicare program, and addressing perverse incentives that led to wasteful spending.

How the Inflation Reduction Act Addressed Wasteful Spending

Most relevant to this hearing is the implementation of the Medicare Part D benefit redesign enacted in the Inflation Reduction Act. This redesign was intended to correct long-standing flaws in the Part D program that distorted incentives for both plan sponsors and drug manufacturers and contributed to excessive and unnecessary spending.

Prior to enactment of the Inflation Reduction Act, the structure of the Part D benefit created perverse incentives for plan sponsors to manage high-priced drugs.[7] In particular, Medicare's reinsurance payments increased as drug spending rose, meaning plan sponsors could face lower financial risk on higher-cost products once beneficiaries reached the catastrophic phase of the benefit. As a result, higher-priced drugs were sometimes preferred over lower-cost therapeutic alternatives. In some cases, high-priced drugs were even less costly for beneficiaries during the coverage gap, and once beneficiaries reached catastrophic coverage, Medicare paid 80 percent of drug costs—further driving up federal spending and encouraging higher launch and list prices.

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[3] U.S. Centers for Medicare & Medicaid Services. (2025). *Medicare Part B inflation rebates fact sheet (CY 2023–2024)*. https://www.cms.gov

[4] U.S. Centers for Medicare & Medicaid Services. (2025). *Medicare Part D inflation rebates fact sheet (applicable period 1 and applicable period 2)*. https://www.cms.gov

[5] Anderson-Cook, A. & Frank, R. (2024). *Impact of federal negotiation of prescription drug prices*. Brookings Institution. https://www.brookings.edu

[6] Anderson-Cook, A. & Frank, R. (2025). *Estimated savings from year two of the IRA prescription drug negotiation program*. Brookings Institution. https://www.brookings.edu

[7] Medicare Payment Advisory Commission. (2020). *Report to the Congress: Medicare payment policy (Chapter 14)*. https://www.medpac.gov

These incentive failures contributed to rapid growth in program spending. Between 2007 and 2018, total Part D spending increased from $46.2 billion to $83.4 billion, an average annual growth rate of 5.5 percent. During this period, Medicare reinsurance was the fastest-growing component of Part D spending, growing at an average annual rate of 16 percent.

The Inflation Reduction Act redesigned the Part D benefit to address these structural weaknesses by reallocating financial responsibility among Medicare, plan sponsors, and drug manufacturers, thereby strengthening incentives to manage costs and limiting wasteful spending. This redesign represents a critical step toward lowering prescription drug costs for beneficiaries and reducing unnecessary Medicare spending.

Congress and the Administration should continue building on this progress by maintaining a focus on lowering prescription drug spending and addressing persistently high drug prices for the American people.

Vertically Integration of Prescription Benefit Managers Undermines Medicare Integrity

Prescription benefit managers, or PBMs, operate at the center of the prescription drug distribution system, serving as intermediaries among drug manufacturers, health plans, pharmacies, and patients. In Medicare Part D, PBMs play a central role in managing formularies, negotiating manufacturer rebates, and administering pharmacy networks. In theory, PBMs' ability to leverage purchasing power and promote cost-effective drug use should help constrain growth in drug prices and beneficiary spending over time.

However, the PBM market has become highly concentrated and vertically integrated. The largest PBMs are owned by the same parent companies that sponsor the largest Medicare Advantage plans, including CVS Health (Aetna–CVS Caremark), UnitedHealth Group (OptumRx), Humana (Humana Pharmacy Solutions), and Blue Cross Blue Shield–affiliated plans through Prime Therapeutics.[8] This consolidation raises important concerns about market incentives, transparency, and regulatory effectiveness.

Increasing vertical integration in the health care industry—particularly among Medicare Advantage and Part D plan sponsors—has weakened the effectiveness of Medicare's Medical Loss Ratio (MLR) requirements. The MLR is intended to ensure that at least 85 percent of Medicare Advantage plan revenues are spent on patient care rather than administrative costs or profits. When a Medicare Advantage plan is owned by a parent company that also controls a PBM or other related health care businesses, that plan can effectively circumvent the MLR constraint through internal transfer pricing.

[8] Federal Trade Commission. (2024). *Pharmacy benefit managers: The powerful middlemen inflating drug costs and squeezing main street pharmacies* (Staff report). https://www.ftc.gov

Specifically, vertically integrated Medicare Advantage plans may pay higher internal prices to affiliated PBMs or pharmacies.[9] These payments are treated as "medical spending" under MLR rules, even when they do not reflect higher costs or increased care delivered to beneficiaries. As a result, profits can be shifted from the regulated insurance entity to affiliated businesses while allowing the plan to appear compliant with MLR requirements. This dynamic undermines the MLR's role as a safeguard for beneficiaries and taxpayers.

Evidence shows that some of the largest Medicare Advantage parent companies now direct a substantial and growing share of plan spending to related businesses.[10] This trend weakens the MLR's effectiveness in constraining excess profits and limiting wasteful spending. Without policy changes—such as enhanced transparency, stronger reporting requirements, or clearer limits on how affiliated transactions are treated under MLR rules—vertical integration will continue to erode Medicare's protections against fraud, waste, and abuse.

Similar concerns have emerged in Medicare Part D following the implementation of MLR requirements. After these regulations were introduced, plan sponsors increased prices paid to their vertically integrated pharmacies by approximately 9.5 percent per prescription relative to prices paid to non-affiliated pharmacies.[11] These increases were concentrated among plan sponsors that were most likely to exceed allowable profit limits, indicating that the pricing behavior was a strategic response to regulation rather than a reflection of rising underlying costs. Importantly, more than 20 percent of these inflated prices were borne by the federal government, resulting in higher Medicare spending.[12] By shifting profits from regulated insurance entities to unregulated affiliated businesses, vertically integrated firms were able to maintain or increase total profits while remaining formally compliant with regulatory requirements.

Another significant concern related to PBM vertical integration is the incentive to steer patients toward affiliated pharmacies, including specialty and mail-order operations. Independent pharmacies report that steering practices create conflicts of interest that can raise prescription drug costs and undermine patient access, particularly in rural and underserved communities where "pharmacy deserts" may develop.[13] Independent pharmacies also report difficulty determining their ultimate reimbursement, given opaque PBM contracts and post-point-of-sale payment adjustments.

Recent analyses indicate that, through these practices, PBM-affiliated pharmacies associated with the three largest PBMs retained nearly $1.6 billion in excess revenue on just two cancer drugs over a

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[9] Frank, R. G., & Milhaupt, C. (2023). *Related businesses and preservation of Medicare's medical loss ratio rules*. Brookings Institution. https://www.brookings.edu/articles/related-businesses-and-preservation-of-medicares-medical-loss-ratio-rules/
[10] Ibid.
[11] Kakani, P., Yde, E., Kanter, G. P., Frank, R. G., & Bond, A. M. (2026). *Profit regulation and strategic transfer pricing by vertically integrated firms: Evidence from health care* (NBER Working Paper No. 35043). National Bureau of Economic Research. https://www.nber.org/system/files/working_papers/w35043/w35043.pdf
[12] Ibid.
[13] Abelson, R. & Robbins, R. (2024). *The powerful companies driving local drugstores out of business*. *The New York Times*. https://www.nytimes.com

period of less than three years.[14] A lack of transparency enables these practices to persist, as key pricing and reimbursement information remains confidential and unavailable to patients, plan sponsors, employers, and regulators.

Taken together, the increasing vertical integration of PBMs and health plans raises serious oversight questions about whether current regulatory frameworks adequately protect Medicare beneficiaries and taxpayers. It also calls into question whether additional statutory or regulatory reforms are necessary to preserve the integrity of the Medicare program in an increasingly consolidated marketplace.

The Public Needs Greater Transparency into Most-Favored-Nation Agreements

In May 2025, President Trump issued an executive order entitled *"Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients,"* directing federal agencies to take steps to align prescription drug prices in the United States with those paid in other developed countries. [15] Following that order, in July 2025, the President sent letters to the chief executive officers of 17 pharmaceutical manufacturers instructing them to negotiate agreements with the Department of Health and Human Services (HHS) and CMS within 60 days.

Those letters outlined several demands, including extending most-favored-nation (MFN) pricing to Medicaid, guaranteeing such pricing for newly launched drugs, returning increased foreign revenues to American patients and taxpayers, and enabling direct purchasing at most-favored-nation prices for self-pay consumers.[16] In the fall of 2025 and continuing through the end of the year, the White House, HHS, and CMS announced that 16 manufacturers had entered into signed agreements with the federal government. These announcements suggested broad commitments, including application of MFN pricing for all drug products for state Medicaid programs, guarantees of MFN pricing for all new drug products, offering of MFN prices for all drugs to self-pay patients, and the repatriation of increased revenues from foreign markets.[17] [18] [19]

However, the details of these agreements have remained confidential. To date, none of these agreements have resulted in demonstrable reductions in drug prices or program spending for patients or taxpayers. Although Freedom of Information Act requests have been submitted to obtain

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[14] Federal Trade Commission. (2024, July). *FTC releases interim staff report on prescription drug middlemen*. https://www.ftc.gov/news-events/news/press-releases/2024/07/ftc-releases-interim-staff-report-prescription-drug-middlemen

[15] Executive Office of the President. (2025, May 15). *Delivering most-favored-nation prescription drug pricing to American patients*. *Federal Register*. https://www.federalregister.gov/documents/2025/05/15/2025-08876/delivering-most-favored-nation-prescription-drug-pricing-to-american-patients

[16] Hollan, M. (2025). *President Trump issues letters to 17 major pharma companies demanding action on most-favored-nation order*. *Pharmaceutical Executive*. https://www.pharmexec.com

[17] Executive Office of the President. (2025). *Fact sheet: President Donald J. Trump announces first deal to bring most-favored-nation pricing to American patients*. https://www.whitehouse.gov

[18] Executive Office of the President. (2025). *Fact sheet: President Donald J. Trump announces first deal to bring most-favored-nation pricing to American patients*. https://www.whitehouse.gov

[19] Executive Office of the President. (2025). *Fact sheet: President Donald J. Trump announces largest developments to date in bringing most-favored-nation pricing to American patients*. https://www.whitehouse.gov

clarity regarding the terms of these agreements, the Administration has not released the agreements, either in whole or in part.[20]

As a result, much of what is known regarding these arrangements has come not from the Administration, but from drug manufacturers themselves through press releases, quarterly earnings calls, and Securities and Exchange Commission (SEC) filings. For example, AbbVie disclosed during a recent shareholder call that its agreement is limited to a three-year term and includes select provisions such as offering lower prices to Medicaid for select drug products, expanding certain direct-to-consumer cash-pay options, receiving relief from tariffs, and obtaining exceptions from future pricing mandates, including CMS demonstrations.[21] These exceptions would include two mandatory Medicare models proposed in late December by the CMS Center Medicare and Medicaid Innovation leverage the Medicare Inflation Rebate Program authorized under the Inflation Reduction Act.[22] [23] However, the proposed rulemaking that was open for public comment did not include a provision for such exception.[24]

Simply, these models would use the prices of other nations to obtain additional rebates for Medicare for certain single-source drugs; the Global Benchmark for Efficient Drug Pricing (GLOBE) for drugs payable under Medicare Part B and Guarding US Medicare Against Rising Drug Costs (GUARD) for drugs covered under Medicare Part D. Both models interact with the existing Medicare inflation rebates in complicated ways operationally that will make them difficult to implement. If such exceptions were included under the MFN agreements they would create competitive market advantages for these 16 drug manufacturers while disadvantaging smaller/newer drug manufacturers who are often considered to be the industry innovators.[25] In addition, since CMS did not propose an exception policy in the draft rulemaking, the public did not have an opportunity to comment which should raise concerns.

Given the magnitude of these agreements and their potential implications for patients, taxpayers, and federal health programs, greater transparency is essential. Congress and the public deserve a clear understanding of what commitments were made, how they are being implemented, and whether they are delivering meaningful savings and lower prices for Americans.

The absence of clear information and transparency from the Administration regarding these agreements raises a number of serious and unresolved questions that warrant Congressional scrutiny. These include:

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[20] Public Citizen v. US Department of Health and Human Services and US Department of Commerce. (2026). *Civil Action No. 26-222. United States District Court District of Columbia*. https://www.citizen.org/wp-content/uploads/1-Complaint-1.27.2026.pdf
[21] AbbVie Inc. (2026). *AbbVie (ABBV) Q4 2025 earnings call transcript*. *The Motley Fool*. https://www.fool.com
[22] Centers for Medicare & Medicaid Services. (2025). *Global Benchmark for Efficient Drug Pricing (GLOBE) model*. *Federal Register*. https://www.federalregister.gov
[23] Centers for Medicare & Medicaid Services. (2025). *Guarding U.S. Medicare Against Rising Drug Costs (GUARD) model*. *Federal Register*. https://www.federalregister.gov
[24] Martin, K., & Sachs, R. (2025). *Administration releases proposed Medicare international drug reference pricing models*. *Health Affairs*. https://www.healthaffairs.org
[25] Frank, R., Martin, K., & Sach, R.E. (2026). *Comments on GLOBE and GUARD drug pricing models*. Brookings Institution. https://www.brookings.edu

- Which specific drugs are covered under the MFN agreements, and whether coverage varies across programs or manufacturers?
- How "most-favored-nation" pricing is defined and operationalized, including which countries, price references, and methodologies are used to calculate those prices?
- The full terms and conditions of the agreements, including what concessions the federal government has offered, such as tariff relief or regulatory exemptions, and the duration of those concessions?
- The length of the agreements and their expiration dates, as well as any provisions for renewal or termination?
- Why drug manufacturers state in quarterly earnings calls and SEC filings that these agreements are not expected to materially affect their revenues, if the stated purpose of the agreements are to lower drug prices and reduce spending?

Without transparency on these fundamental questions, it is difficult for Congress or the public to assess whether these agreements are delivering meaningful savings for patients and taxpayers, or whether they primarily benefit manufacturers without achieving their stated policy goals.

Most-Favored-Nation Agreements and TrumpRx Require Further Examination

In September 2025, the Administration announced the development of TrumpRx, a federal government website intended to allow patients to obtain prescription drugs at deeply discounted prices based on MFN agreements with drug manufacturers.[26] At the time, the Administration stated that TrumpRx would be available to patients by January 2026 and would deliver significant savings to Americans.

After multiple delays, TrumpRx.gov launched in February 2026 offering just 43 drugs from five manufacturers, accompanied by claims of "massive, immediate savings to millions of Americans."[27] As of today, the platform lists approximately 80 drugs, far fewer than the broad universe of products that were implied to be covered under the MFN announcements. Moreover, the prices offered through TrumpRx generally do not reflect substantial or immediate savings for the majority of patients.

TrumpRx is also not a novel or transformative model. Rather, it functions as an online platform that provides printable manufacturer coupons that can be used at retail pharmacies by patients paying cash outside of insurance. TrumpRx does not offer true direct-to-consumer purchasing; patients cannot buy medications directly through the website. In nearly all cases, the platform directs users to print coupons that resemble those offered by existing services such as GoodRx and similar discount aggregators. In addition, many of the same discounted prices available on TrumpRx can

[26] Government Publishing Office, Remarks on Prescription Drug Prices and an Exchange With Reporters (Sept. 30, 2025). https://www.govinfo.gov/app/details/DCPD-202500972
[27] The White House. (2026). *President Trump launches TrumpRx.gov, delivering massive, immediate savings to millions of Americans*. https://www.whitehouse.gov

already be accessed directly through drug manufacturers' websites. A valid prescription is still required, and these discounts generally cannot be used by insured patients, including those covered by Medicare or Medicaid.

As implemented, TrumpRx has raised significant concerns about accuracy and consumer understanding, which you could argue is a form of fraud. First, despite the implications of the MFN agreements, TrumpRx does not include many of the most commonly used or highest-cost drugs, including medications for cardiovascular disease, diabetes, autoimmune conditions, and cancer.[28] Second, many of the drugs listed on TrumpRx already have much lower-priced generic alternatives widely available to patients.[29] Third, other platforms—such as Mark Cuban's Cost Plus Drugs and GoodRx—frequently offer lower prices on the same brand-name drugs, calling into question claims that TrumpRx reflects MFN pricing when the prices are not even the lowest available domestically.[30] Fourth, TrumpRx appears to, in some cases, rely on temporary introductory discounts that are used to initiate therapy but are subsequently replaced by higher prices or eliminated entirely.[31] Fifth, despite claims to the contrary, many TrumpRx prices remain higher than prices paid in other developed countries, even under the Administration's own MFN rhetoric.[32] Finally, there is limited transparency regarding the backend operations of TrumpRx, including financial arrangements, vendor relationships, and compliance with federal conflict-of-interest and anti-kickback laws. Public reporting has raised questions about the Trump family's ties to BlinkRx, a private company that operates a similar pharmacy platform, further underscoring the need for disclosure and oversight.[33] [34] [35] [36] [37] [38] [39]

Taken together, these issues suggest that TrumpRx, as currently structured, does not fulfill the promises made under the MFN agreements and risks misleading the public about the availability and magnitude of prescription drug savings. Congress should closely examine both the substance of the MFN agreements and the implementation of TrumpRx to determine whether they are delivering measurable benefits for patients and taxpayers. These include:

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[28] Robbins, R. (2026). *Trump Promised the 'World's Lowest' Drug Prices. We Checked the Numbers. The New York Times*. https://www.nytimes.com

[29] WIlkerson, J. et al (2026). *TrumpRx promises cheapest drugs. Many cost less already. STAT*. https://www.statnews.com

[30] Ashtari, N. (2026). *TrumpRx discounts only one drug while 22 million Americans see costs rise*. Center for American Progress. https://www.americanprogress.org

[31] Robbins, R. (2026). *Trump Promised the 'World's Lowest' Drug Prices. We Checked the Numbers. The New York Times*. https://www.nytimes.com

[32] Ibid.

[33] Cohrs Zhang, R. (2025). *Firm tied to Trump Jr. debuts direct sales product for pharma. Bloomberg*. https://www.bloomberg.com/news/articles/2025-08-11/firm-tied-to-trump-jr-debuts-direct-sales-product-for-pharma

[34] AInvest. (2025). *Pharma DTC disruption: Trump Jr.-backed innovation reshaping drug delivery profit margins*. https://www.ainvest.com/news/pharma-dtc-disruption-trump-jr-backed-innovation-reshaping-drug-delivery-profit-margins-2508/

[35] Linskey, A. & Dawsey, J. (2025). *TrumpRx, drug companies, and BlinkRx raise questions about pharmacy pricing. The Wall Street Journal*. https://www.wsj.com/health/pharma/trumprx-drug-companies-blinkrx-2b6e1761

[36] Wilson, M.R. (2025). *TrumpRx, big pharma, and AMA billing codes* (Health brief). *The Washington Post*. Washington Post Intelligence. https://www.washingtonpost.com/wp-intelligence/health-brief/2025/10/08/trumprx-big-pharma-ama-billing-codes/

[37] Taylor, P. (2025). *TrumpRx, BlinkRx, GoodRx – what's going on in DTC sales? Pharmaphorum*. https://pharmaphorum.com

[38] Jones, J. (2025). *Trump family profits, TrumpRx, and BlinkRx raise ethics concerns*. *MSNBC*. https://www.msnbc.com/top-stories/latest/trump-family-trumprx-blinkrx-junior-rcna236748

[39] Durbin, D. et al. (2026). *Letter to the Department of Health and Human Services Office of Inspector General regarding TrumpRx*. United States Senate. durbin_hhs_oig_letter_on_trumprx.pdf

- How many patients have actually used TrumpRx, and what savings have they experienced on average?
- Why do advertised TrumpRx prices often exceed prices paid in other high-income countries or available through existing U.S. platforms?
- If TrumpRx pricing is truly MFN-based, why is it not consistently the lowest price available in the U.S. market?
- How does the Administration reconcile claims of "massive, immediate savings" with the limited number of drugs offered and modest price reductions observed?
- What additional value does TrumpRx provide beyond existing commercial coupons and discount platforms?
- Are the discounts offered through TrumpRx permanent or time-limited, and how often do prices increase after introductory periods?
- What safeguards exist to prevent bait-and-switch pricing, particularly for high-demand drugs such as GLP-1s?
- How is the Administration monitoring manufacturer behavior after patients initiate therapy through TrumpRx?
- What federal resources were used to develop, operate, and promote TrumpRx?
- Does TrumpRx comply with federal anti-kickback, consumer protection, and marketing laws?
- Have any waivers or exemptions been granted to manufacturers or platform operators as part of these agreements?
- What entities operate the backend infrastructure of TrumpRx?
- What steps has the Administration taken to identify and mitigate potential conflicts of interest, including concerns related to private companies offering similar platforms?
- Has the Office of Government Ethics or HHS Inspector General reviewed TrumpRx and the MFN agreements?

Lowering Prescription Drugs Costs Require Transparency and Expansion of Policies that Work

And while I am proud of the work under the Inflation Reduction, there is more to be done. At a high level, there are three steps to lower prescription drug costs in this country:

- Expand the Medicare negotiated prices, also called Maximum Fair Prices, so the commercial market so that people with private insurance and those without insurance can access the same lower drug prices as Medicare.
- Authorize Medicare negotiate prices for drugs sooner if they are unaffordable, including if they are blockbuster drugs and reduce the number of years for when the drugs become eligible for negotiation.
- Extend the Medicare inflation rebate policy, limiting annual price increases on drugs to the commercial market.

Conclusion

In conclusion, Medicare has long delivered high-quality care to nearly 70 million Americans and Inflation Reduction Act enabled the most significant reforms to Medicare Part D since the program's creation. These reforms corrected perverse incentives, reduced wasteful spending, and have already generated meaningful savings for beneficiaries and taxpayers through inflation rebates, drug price negotiation, and a redesigned Part D benefit.

I urge this Committee to address the serious concerns about the Administration's opaque MFN agreements and the implementation of TrumpRx. As I have highlighted, there is a lack of transparency, questionable consumer savings, and potential conflicts of interest associated with these initiatives. Unlike the statutory, accountable reforms enacted through the Inflation Reduction Act, these efforts have not demonstrated clear or measurable benefits. I conclude by urging Congress to exercise strong oversight, demand transparency, and continue building on proven policies that protect beneficiaries, safeguard taxpayer dollars, and sustainably lower prescription drug costs.

Thank you for inviting me to testify. I look forward to working with you to address the challenges of Americans to afford their prescription drugs and address high prescription drug prices.

Thank you,
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