January 28, 2026

Chairwoman Brenda Dietrick, Vice Chair Michael Fagg
Members of the Senate Committee on Financial Institutions and Insurance

Dear Chairwoman Dietrick, Vice Chairman Fagg and Members of the Committee:

Thank you for the opportunity to submit testimony on this important issue. My name is Alex Byrnes, and I am the Government Relations Director for Hy-Vee, covering Kansas, Missouri, and Nebraska.

Here in Kansas, Hy-Vee operates 11 grocery stores with pharmacies, serving communities that range from the Kansas City metro to Manhattan. Our pharmacies not only serve residents within those communities, but also patients from surrounding towns and rural counties who rely on accessible, reliable pharmacy care close to home. While Hy-Vee operates at scale, the issues discussed before you today are neither isolated nor theoretical. They show up every day at our pharmacy counters and directly affect the patients we serve.

PBM reform is critical to Hy-Vee because it is critical to our patients.

Across Kansas, regardless of geography or pharmacy type, we continue to see the same patterns repeated. Patients are increasingly frustrated by unpredictable out-of-pocket costs, and many abandon prescriptions they can no longer afford. Others are shocked to learn that their pharmacy was reimbursed less for a medication than it cost to acquire, let alone paid a dispensing fee.

These are not rare occurrences. They are not driven by market forces pharmacies can control, and they are not the result of a functioning free market. Instead, they reflect opaque PBM practices that distort reimbursement, patient cost-sharing, and access to care.

The consequences of these practices are already visible across Kansas. Since 2015, more than 110 pharmacies have closed statewide, including 16 in 2025 alone, leaving many communities without reliable access to a pharmacy. If trends continue, at least 11 additional pharmacies are projected to close in 2026. The impact is especially acute in rural areas, where the local pharmacy is often one of the only accessible health care provider. Today, two Kansas counties have no pharmacy at all, 41 counties are served by only one remaining pharmacy, and 67 percent of Kansas towns lack pharmacy access within a five-mile radius.

PBM practices — such as below-cost reimbursement, retroactive clawbacks, hidden fees, restrictive networks and lack of transparency — contribute directly to pharmacy instability. For the same prescription, PBMs routinely pay pharmacies one amount while billing employers

significantly more and pocketing the difference. Between 2020 and 2023, plan sponsor costs increased by approximately 30 percent, while commercial pharmacy reimbursement declined by roughly 3 percent. On average, employers are paying approximately $8 more per prescription than what pharmacies are reimbursed, representing nearly an 80 percent spread on many generic drug transactions.

These pricing distortions are particularly troubling for critical medications. For the widely used addiction treatment drug buprenorphine-naloxone, pharmacies were reimbursed an average of $18.77 below their acquisition cost, while employers were billed $100.12 above the underlying drug cost for the same prescription. These are not isolated incidents, they reflect systemic pricing practices that inflate employer costs while destabilizing pharmacies that dispense essential medications.

Similarly, plan sponsors are being charged an average of $4,465 for the drug teriflunomide through PBM-affiliated mail order pharmacies, even though that same medication can be purchased through the Mark Cuban Cost Plus Drug Company for less than $20. These examples raise serious questions about transparency, incentives, and whether PBM practices are aligned with patient and employer interests.

When pharmacies are strained, patients feel the impact first. When a community loses a pharmacy patients lose more than a place to fill prescriptions — they lose a trusted health care access point for counseling, medication management, and preventive care. At the same time, we have seen increased use of PBM-driven mail order requirements that steer patients away from their local pharmacy, even when a community pharmacy is available and willing to serve them. While mail order may be appropriate for some patients, it should not replace patient choice or come at the expense of timely, in-person care, particularly for seniors, rural residents, and patients managing complex or urgent medication needs.

Behind every prescription is a pharmacist providing care that extends well beyond dispensing a pill. Our pharmacists routinely fill prescriptions and deliver medications within an hour, communicate with prescribers and insurers to resolve coverage issues, and provide medication counseling that keeps patients on therapy and out of the hospital. When I asked our pharmacists about this work, their response was simple, *"This is just what we do. It's second nature to us."* These services are essential to patient outcomes, yet they are routinely undervalued or uncompensated under current PBM models.

The corporate structures behind PBMs may be invisible to patients, but the consequences are not. In 2025, the Federal Trade Commission found that PBMs marked up generic drugs by more than 1,000%, with some individual drugs exceeding 7,000%, while directing patients to affiliated

pharmacies and extracting billions in revenue and negatively impacting employers, patients and pharmacies. When PBM practices destabilize pharmacies across the board, patients lose options, face delays in care, and ultimately lose access to timely, affordable care close to home.

We also recognize concerns raised by employers and self-funded health plans. What is important about PBM reform is that it focuses on transparency, fair reimbursement and accountability, and does not introduce new costs into the system. Instead, it shines a light on existing pricing practices and gives plan sponsors greater visibility into where their health care dollars are actually going. Available data shows no discernible difference in premium trends between states that have enacted PBM reform and those that have not.

Rising prescription drug costs are driven by upstream pricing and PBM practices, not by pharmacies dispensing medications at or below cost. PBM reform does not increase the price of medications; it ensures pharmacies are reimbursed fairly for both the cost of the drug and the professional service of dispensing it, all while protecting patient access to care. That is why Hy-Vee supports PBM reform that prioritizes transparency, fair reimbursement and accountability, restoring balance to a system that currently lacks meaningful oversight and ensuring it works for all patients, regardless of where they live or where they fill their prescriptions.

We see the consequences of inaction every day through the patients and communities we serve.

This legislation represents an important step toward protecting patient access, strengthening pharmacy sustainability, and improving trust in the prescription drug system.

Thank you for your time and consideration.

Respectfully submitted,

Alex Byrnes
Director, Government Relations
Hy-Vee, Inc.