

Testimony in Support of the PBM Kickback Prohibition Act

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Committee on Education and Workforce
Subcommittee on Health, Employment, Labor, and Pensions

Hearing on:
“Profits Over Patients: The PBM Business Model Under Scrutiny”

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I. Introduction and Background

Chairman, Ranking Member, and Members of the Subcommittee:

Thank you for the opportunity to submit testimony in support of the PBM Kickback Prohibition Act.

I work with a broad range of stakeholders across the healthcare system, including self-funded employers, labor unions, governmental entities, nonprofit advocacy organizations, and employer purchasing coalitions. In that capacity, I advise plan sponsors responsible for tens to hundreds of millions of dollars in annual healthcare spending—entities that, under the Employee Retirement Income Security Act (ERISA), are legally obligated to act solely in the best interests of their employees and beneficiaries.

Prior to this work, I served in a senior leadership role overseeing the New Jersey State Health Benefits Program (SHBP), one of the largest public employer health plans in the United States, covering approximately 800,000 public employees, retirees, and their families. In that role, I was directly responsible for evaluating and negotiating contracts with pharmacy benefit managers (PBMs), overseeing broker and consultant relationships, and managing the financial and operational performance of the program.

During my tenure, I was also directly involved in identifying and addressing improper financial arrangements within the healthcare system, including work that contributed to securing the largest False Claims Act settlement in New Jersey state history. That experience underscored how opaque financial relationships and misaligned incentives can persist undetected—even in large, sophisticated systems—and how significant the consequences can be when they are uncovered.

Across both public and private sector experience, I have worked extensively with the underlying data, contracts, and financial arrangements that determine how prescription drug benefits are structured and paid for. This includes reviewing pricing guarantees, rebate arrangements, administrative fee structures, and the flow of funds between PBMs, brokers, consultants, and other intermediaries.

What I have seen consistently—across markets, across vendors, and across plan types—is that the entities advising employers and plan sponsors are often not financially aligned with the plans they are retained to serve. Compensation arrangements tied, directly or indirectly, to PBMs and related entities can create incentives that are not visible to the plan sponsor, not clearly disclosed, and difficult to evaluate even with significant expertise and access.

For plan sponsors operating under ERISA, this creates a fundamental problem. They are held to a fiduciary standard that requires prudence, loyalty, and informed decision-making—yet the structure of the marketplace often denies them the transparency and alignment necessary to meet that obligation.

This testimony reflects that experience—not from a theoretical perspective, but from direct involvement in the decisions, data, and contractual arrangements that shape how prescription drug benefits are purchased in the United States today.

II. Misaligned Financial Incentives in the PBM Market

To understand why this legislation is necessary, it is important to understand how prescription drug benefits are actually purchased and managed today.

Most employers and plan sponsors do not contract directly with drug manufacturers. Instead, they rely on pharmacy benefit managers, or PBMs, to design formularies, negotiate rebates, process claims, and manage pharmacy networks. They also rely on brokers and consultants to advise them on which PBM to select and how those contracts are structured.

In practice, these relationships are not independent.

PBMs generate revenue through a number of mechanisms, including retained rebates, spread pricing, administrative fees, and payments tied to the placement of drugs on formularies. Many of these revenue streams are not fully visible to the employer, even in large and sophisticated plans. Reporting is often limited to summary guarantees or aggregate rebate figures, without access to the underlying data needed to verify how those amounts were calculated.

At the same time, brokers and consultants may receive compensation that is tied, directly or indirectly, to the PBM arrangements they are advising on. This compensation can take many forms, including commissions, administrative payments, consulting fees, or other financial relationships that are not clearly disclosed in a way that allows a plan sponsor to evaluate them.

The result is a structure in which the entity responsible for advising the plan sponsor may have a financial relationship with the entity being evaluated. In this environment, higher drug spend can generate higher revenue at multiple points in the system. A drug with a higher list price may produce a larger rebate. A larger rebate increases the total dollars flowing through the PBM. Those dollars do not stop at the PBM.

For example, CVS Health operates CVS Caremark alongside affiliated entities including Zinc Health Services, which aggregates rebate negotiations, as well as specialty and retail pharmacies that dispense medications. Revenue can be generated through manufacturer rebates, pharmacy dispensing margins, and administrative fees across affiliated entities. Cigna operates Express Scripts within its Evernorth platform, which includes group purchasing and specialty pharmacy operations. A single formulary decision can influence rebate flows, pharmacy utilization, and service revenue across that broader platform. UnitedHealth Group operates Optum Rx as part of Optum, which includes affiliated provider groups and pharmacies. In this model, prescription drug decisions may have financial implications that extend beyond the PBM to other parts of the organization.

In practice, these dynamics can produce results that appear favorable to the plan sponsor on the surface, while masking higher underlying costs. For example, a PBM contract may report that it has met or exceeded its pricing guarantees, including rebate guarantees or discount targets. Those guarantees are often presented as evidence of strong performance. However, those same results may be driven by higher list prices, increased utilization of higher-cost drugs, or formulary decisions that maximize rebate volume rather than minimize net cost. In that scenario, the plan sponsor may see a surplus against contractual guarantees, while total spending continues to increase. The metrics being reported are technically accurate, but they do not fully reflect how costs are being generated or how financial incentives are operating across the system.

Similarly, arrangements that are described as administrative or consulting fees may appear routine and unrelated to pricing decisions. In practice, those payments may be tied to broader financial relationships that influence which PBMs are selected, how formularies are structured, or how procurement processes are managed, as described more fully below.

In each of these examples, the issue is not the existence of these entities. The issue is that financial incentives are distributed across multiple affiliated businesses in ways that are not fully visible to the employer purchasing the benefit.

In addition to these financial flows, it is important to understand how purchasing decisions are made in practice.

Most employers do not directly run competitive procurements for PBM services. They most often rely on brokers or consultants to design and manage the request for proposal, or RFP, process. This includes determining which PBMs are invited to bid, how the bid is structured, what information is requested, and how responses are evaluated.

This creates a critical point of control.

The consultant or broker is effectively acting as the gatekeeper to the market. They decide which PBMs are included in the process and which are not. They also define the terms of the competition, including how pricing is presented and what guarantees are emphasized.

In some cases, PBMs enter into financial arrangements with brokers or consultants that are tied to participation in these processes. These arrangements are not always described as commissions. They may be structured as consulting fees, administrative service payments, data access fees, or broader commercial agreements tied to a consultant's overall book of business. For example, a PBM may pay a consultant for access to a portfolio of employer clients, for inclusion in preferred vendor programs, or for participation in standardized procurement processes managed by that consultant. These payments may not be disclosed in a way that allows the employer to understand how they relate to the recommendations being made. In this environment, the RFP process may appear competitive on the surface, while in reality the field of bidders has already been shaped by financial relationships that are not visible to the plan sponsor.

Even when multiple PBMs are included, the structure of the bid can influence the outcome. Pricing may be presented in a way that emphasizes rebate guarantees over net cost, or administrative fees over total cost of care. Key contract terms, including audit rights, data access, and definitions of pricing metrics, may not be standardized or may not be fully disclosed during the evaluation process.

As a result, employers may believe they are conducting a competitive procurement and receiving independent advice, when in fact the process itself may be influenced by financial relationships that are not transparent. From the perspective of the employer, these arrangements are difficult to identify and even more difficult to quantify. In many cases, plan sponsors do not have access to the underlying claims-level data, rebate detail, or contractual terms necessary to fully understand how pricing decisions are being made or how compensation is structured across entities.

These limitations can extend to the procurement process itself. Employers often rely on consultants to run PBM procurements, yet may not be provided with full access to the underlying bidding materials, including questionnaires, evaluation criteria, or the complete set of vendor responses. Without access to these materials, plan sponsors are not in a position to independently assess how bids were structured, how vendors were evaluated, or whether the process was conducted on a fully transparent and competitive basis. This creates a clear conflict with the expectations placed on employers under ERISA. Plan sponsors are required to act prudently and solely in the interest of plan participants. However, they are often making decisions based on incomplete information, with advice that may be influenced by financial relationships that are not fully transparent.

The issue is not that individual actors are behaving improperly in every case. The issue is that the system is designed in a way that allows misaligned incentives to exist without clear visibility or accountability. The PBM Kickback Prohibition Act addresses this issue directly by targeting compensation arrangements that tie advisor incentives to PBM business. By removing those financial connections, the bill helps ensure that the entities advising plan sponsors are aligned with the plans they serve.

III. How These Incentives Operate in Practice

The following examples illustrate how these dynamics operate in practice. Where applicable, supporting documentation is included as exhibits.

Example 1: Required consulting fees tied to participation in the procurement process

In some procurement processes, bidders are required to agree to pay fees directly to the consultant managing the process as a condition of participation.

As shown in Exhibit A, a procurement questionnaire issued by a major PBM consulting firm requires that “the bidder agrees to pay a consulting fee of \$3.50 per employee per month (or equivalent value) directly” to the consultant on an ongoing basis. This payment is not made by the employer. It is paid by the PBM or bidding vendor.

Similarly, as shown in Exhibit B, a separate procurement document issued by a large consulting and brokerage firm states that the RFP “includes consulting fee of \$50,000 to be paid on an annual basis, beginning immediately following the effective date,” with additional detail to be provided upon award of the business.

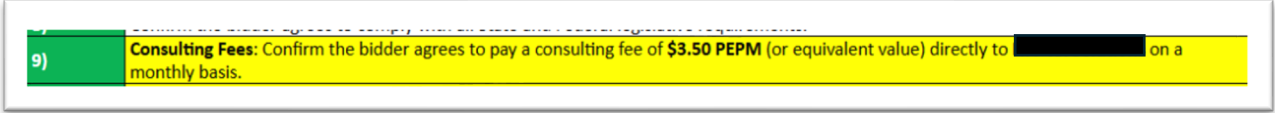


Exhibit A- Questionnaire from Major PBM Consulting Firm (2025)

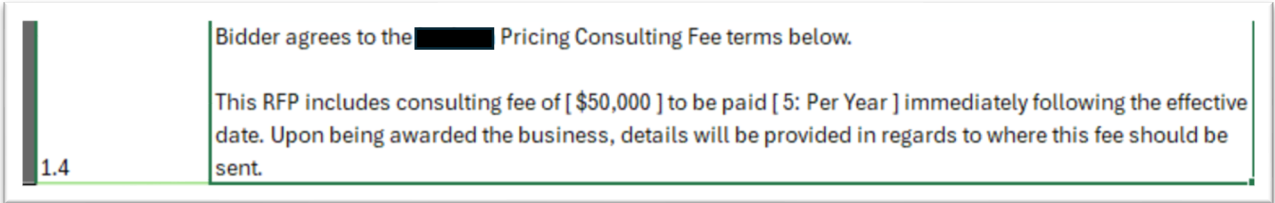


Exhibit B – Questionnaire from Major Consulting/Brokerage Firm (2026)

These types of requirements have several implications.

First, they establish a direct financial relationship between the consultant running the procurement and the vendors being evaluated. Second, where compensation is structured on a per member or per claim basis, total payments increase with the size of the plan, the level of utilization, and the duration of the contract. Third, these payments may not be presented to the employer as part of the total cost of the PBM arrangement, even though they are a required condition of participation in the process.

From the employer’s perspective, the procurement may appear to be independent and competitive. However, the structure of the process itself creates a financial connection between the advisor and the vendors seeking to win the business.

Example 2: Contractual structures that embed financial flows and limit transparency

In addition to procurement-stage arrangements, contract terms themselves can establish financial structures that are not fully visible or controllable by the plan sponsor.

As shown in Exhibit C, a participating group addendum between a PBM and a consulting firm includes provisions for payments and credits that flow between the PBM and the consultant, rather than directly between the PBM and the plan sponsor.

This Addendum (“Addendum”) supplements the Amended and Restated Gallagher Master Prescription Benefit Services Agreement (“Master Agreement”) between CaremarkPCS Health, L.L.C., a Delaware limited liability company (“CVS Caremark”), and Gallagher Benefit Services, Inc. (“Gallagher”), dated as of January 1, 2024, as amended or restated. All capitalized terms used in this Addendum shall have the meaning set forth in the Master Agreement.

[.....]

9. The following credits apply to Participating Group:

A. Additional Credit. CVS Caremark shall remit to Gallagher, within forty-five (45) days after each calendar quarter, on behalf of Participating Groups, with an additional credit of seven dollars (\$7.00) per mail/maintenance choice, specialty, and Retail-90 day Claim and two dollars and fifty cents (\$2.50) per Retail 30 Claim (excluding [one hundred percent] 100% member paid plans) (“Additional Credit”). It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute and any required government reporting, the credit shall constitute and shall be treated by each Participating Group as a discount against the price of drugs within the meaning of 42 U.S.C. § 1320a-7b(b)(3)(A). Payment of the credit shall be subject to each Participating Group’s written agreement to such treatment and reporting of the credits.

B. General Administrative Credit. Provided Participating Group signs a Participating Group Addendum, CVS Caremark shall provide Participating Group with a general administrative credit in an amount up to two dollars and fifty cents (\$2.50) per Member annually which will be available during each year of a full three (3) year Initial Term or three (3) year Renewal Term. CVS Caremark shall provide a payment of mutually agreed upon administrative allowances relating to expenses incurred in connection with the administration of Participating Group’s prescription benefit management business. Examples of appropriate expenses include costs of newly implemented clinical programs, customized Plan Participant Identification Cards, postage expense for direct mail

Exhibit C – Participating Group Addendum, 1/1/2024-12/31/2026

For example, the agreement provides for an “Additional Credit” to be remitted by the PBM to the consulting firm on behalf of participating groups, calculated on a per-claim basis, including seven dollars per mail, specialty, and 90-day retail claim and two dollars and fifty cents per 30-day retail claim.

The agreement also provides for a “General Administrative Credit” tied to expenses incurred in connection with administering the plan, including consulting fees and other vendor-related costs.

In addition, the contract places restrictions on transparency. Participating groups are prohibited from disclosing financial and operational terms of the agreement, and pharmacy claims data made available to the plan sponsor or its vendors may have key pricing components, including rebate amounts and dispensing fees, removed or redacted. The agreement further restricts the ability of the plan sponsor to independently negotiate rebate arrangements with manufacturers or other third

parties. Taken together, these provisions illustrate how financial flows and data limitations can be embedded directly in the structure of the agreement.

To understand how these economics work in practice, consider a jumbo employer with 100,000 covered lives participating in this type of arrangement.

First, the agreement provides that CVS Caremark will remit to Gallagher an “Additional Credit” of \$7.00 per mail, specialty, and 90-day retail claim, and \$2.50 per 30-day retail claim. The same agreement also states that CVS Caremark will make available a “General Administrative Credit” of up to \$2.50 per member annually, and that these administrative allowances may include consulting fees and audit costs related to transparency. It further provides that CVS Caremark will begin filling prescriptions through its mail service pharmacies and that claims data made available to the participating group may have AWP pricing components, rebates, and dispensing fees redacted or removed from view.

Now assume that this 100,000-life employer generates 1 million annual pharmacy claims. If 600,000 of those claims are traditional 30-day retail claims, Gallagher would receive \$1.5 million from CVS on those claims alone. If another 250,000 claims are filled through 90-day retail, mail, or specialty channels, Gallagher would receive an additional \$1.75 million on those claims. That produces \$3.25 million in annual claim-based payments before taking into account the separate general administrative credit. If the full administrative credit were made available at \$2.50 per member per year, that would add another \$250,000 annually. On this simple hypothetical, the total annual economic value flowing from CVS to Gallagher could reach roughly \$3.5 million.

The point is not just the size of the payment. It is the direction of the incentive.

Under this structure, Gallagher has an economic interest in claim volume, and especially in the categories of claims that generate the higher \$7.00 credit. Those include mail, specialty, and 90-day retail claims. The more prescriptions that move into those categories, the more compensation Gallagher receives from CVS.

CVS has the same directional incentive. CVS does not simply process those claims as a neutral administrator. The agreement specifically contemplates fulfillment through CVS mail service pharmacies, and the broader CVS model includes owned or affiliated dispensing channels. That means more scripts routed to mail, specialty, and 90-day channels can create value for CVS not only through the PBM contract itself, but also through the dispensing channel where CVS participates in the economics of the fill.

So the economics run in the same direction for both parties. Gallagher benefits when more prescriptions are driven into the higher-credit channels. CVS benefits when more prescriptions are driven into channels where it is not only administering the benefit, but also participating in the dispensing economics through its vertical structure.

From the employer’s perspective, that is the core concern. What may be presented as a credit, allowance, or administrative arrangement is also a set of incentives that can reward increased script volume and channel migration. And because the same agreement restricts disclosure of financial

and operational terms and permits key pricing elements to be redacted from the claims data, the employer may have limited ability to test whether those incentives are affecting plan design, channel strategy, or total net cost.

The agreement further specifies that, for purposes of federal law, the additional credit is to be treated as a discount against the price of drugs. That distinction between how a payment is labeled and how it functions economically is central to understanding why these arrangements deserve scrutiny.

Example 3: Compensation Requirements as a Condition of Participation in PBM Procurements

To understand how these dynamics can influence vendor selection, consider a procurement process for a large employer with 50,000 to 100,000 covered lives.

The employer typically delegates responsibility for the request for proposal, or RFP, to a consultant. The consultant determines which PBMs are invited to bid, designs the questionnaire, collects responses, and presents a recommendation. As shown in Exhibits A and B, bidders in some processes are required to agree to pay consulting fees directly to the firm managing the procurement as a condition of participation. These fees may be structured on a per member basis, as a fixed annual amount, or tied to claim volume. In practice, this means that a PBM seeking to participate in the process must agree in advance to a financial relationship with the consultant running that process.

Now consider how the structure of the RFP can influence the outcome. The questionnaire may emphasize certain pricing metrics, such as rebate guarantees or discount percentages, rather than net cost after all financial flows are considered. Vendors may be required to present pricing in standardized formats that do not fully capture differences in underlying economics, including the impact of channel mix, specialty drug utilization, or affiliated dispensing arrangements. At the same time, the employer may not have access to the full set of bidding materials, including the detailed questionnaires, vendor responses, or scoring methodologies used to evaluate the bids. In some cases, these materials are not shared or are only provided in summary form. As a result, the employer is often relying on the consultant's interpretation of the bids, rather than independently reviewing the underlying submissions.

Taken together, these elements create a process that may appear competitive, while still being influenced by financial relationships and structural constraints that are not visible to the plan sponsor. A PBM that agrees to the required fee structure, aligns with the evaluation framework, and participates in the consultant's broader commercial relationships may be more likely to advance in the process. A PBM that does not agree to those terms may not be included or may not be competitive within the structure of the bid. From the employer's perspective, the outcome is presented as the result of a competitive evaluation. However, the conditions of participation, the structure of the bid, and the flow of information may have already shaped that outcome.

This affects not only pricing, but which PBMs are able to participate in the procurement at all. PBM procurements are complex and highly technical. Requests for proposal often include detailed

questionnaires, pricing templates, utilization assumptions, and contractual requirements that can span dozens to hundreds of pages. Evaluating these materials requires specialized expertise in areas such as rebate structures, claims adjudication, network pricing, and pharmacy channel dynamics.

As a practical matter, most employers do not have the internal resources to independently design or evaluate these procurements. Instead, they rely on consultants and brokers to structure the RFP, manage the bidding process, and interpret vendor responses. Examples of these types of procurement documents are publicly available and include, for example:

Request for Proposal issued by the State of Delaware for pharmacy benefit manager services covering approximately 132,000 members, including detailed scope of services, pricing requirements, and reporting obligations.

<https://dhr.delaware.gov/benefits/sebc/documents/2025/0425-pbm-scope-of-services.pdf>

Supplemental RFP materials outlining required PBM functions, including claims adjudication, rebate reporting, pricing models, and performance guarantees, illustrating the level of technical detail required in PBM procurements.

<https://dhr.delaware.gov/benefits/sebc/documents/2025/0307-pbm-rfp-scope-of-work.pdf>

Request for Proposal issued by the Mississippi State and School Employees' Health Insurance Management Board seeking PBM services for a large, self-insured public plan, including detailed contractual terms, reporting requirements, and integration with multiple vendors and consultants.

<https://www.dfa.ms.gov/sites/default/files/Procurement%20Contracts%20Home/Active%20Procurements/DFA%20Active%20Procurements/RFX%20%233120003010/State%20of%20Mississippi%20RFP%20for%20PBM%20Services%2020241016.pdf>

This reliance is necessary. At the same time, it underscores the importance of alignment. Where the entity responsible for structuring and evaluating the procurement has financial relationships with the vendors being evaluated, the employer may have limited ability to independently assess how the process is conducted or how outcomes are determined.

Example 4: Consultant Control of Procurement Structure and Evaluation

In addition to the participation requirements described above, the structure of the procurement process itself can influence vendor selection.

Employers typically delegate responsibility for the request for proposal, or RFP, to a consultant. That consultant determines which PBMs are invited to bid, designs the questionnaire, manages vendor communications, collects responses, and supports the evaluation and recommendation. As shown in Exhibits A and B, bidders in some processes are required to agree to pay consulting fees directly to the firm managing the procurement as a condition of participation. In those cases, a

PBM must agree in advance to a financial relationship with the consultant in order to compete for the business.

Publicly available procurements show how much control is exercised over the structure and evaluation of these competitions.

For example, in the State of Delaware PBM RFP (2025), the procurement includes a detailed questionnaire and specifies that proposals will be evaluated based on defined criteria and weighted scoring. The RFP requires vendors to submit pricing in a standardized format and evaluates components such as rebate guarantees, discount levels, and administrative fees. This structure determines how proposals are compared and which attributes are prioritized in the evaluation.¹

In the State of Mississippi PBM RFP (2024),² the document states that the procurement is conducted “with assistance from its consultant, Gallagher Benefit Services.” The consultant’s role includes supporting the development of the RFP, coordinating the procurement process, and assisting in the evaluation of vendor responses. This places the consultant in a central position in both structuring the competition and influencing how proposals are assessed.

In the University of Maine System PBM RFP (2025),³ the procurement materials include detailed response requirements and technical submission components that are distributed through controlled channels. Vendors are required to follow specific templates and instructions, and access to certain materials and clarifications is managed as part of the procurement process. This reflects a structured, consultant-managed environment rather than an open, unstructured competition.

These documents demonstrate several consistent features across PBM procurements. First, the consultant plays a central role in defining the structure of the competition, including the questions that are asked, the format in which pricing must be presented, and the criteria used to evaluate responses. Second, the evaluation framework emphasizes specific metrics, such as rebate guarantees and discount percentages, which may not fully reflect total net cost after all financial flows, including rebates retained, channel economics, and affiliated revenue, are considered. Third, the plan sponsor may not have direct access to the full set of underlying materials, including detailed vendor responses, scoring methodologies, and assumptions used in evaluation, and instead relies on summaries and recommendations prepared by the consultant.

When viewed alongside the compensation arrangements described above, this structure creates a situation in which the same entity may influence which vendors participate, how proposals are framed, how bids are evaluated, and how recommendations are presented to the employer. Where compensation is tied, directly or indirectly, to PBM relationships, these roles take on additional significance. A PBM that agrees to required fee structures or maintains broader financial relationships with the consultant may be more likely to participate in and advance through the procurement process. A PBM that does not agree to those terms may not be included or may not be competitive within the structure of the bid. From the employer’s perspective, the procurement may appear to be independent and competitive. However, when financial relationships exist

¹ See Attachment 1; See also https://dhr.delaware.gov/benefits/sebc/sebc-materials.shtml?utm_)

² Id.

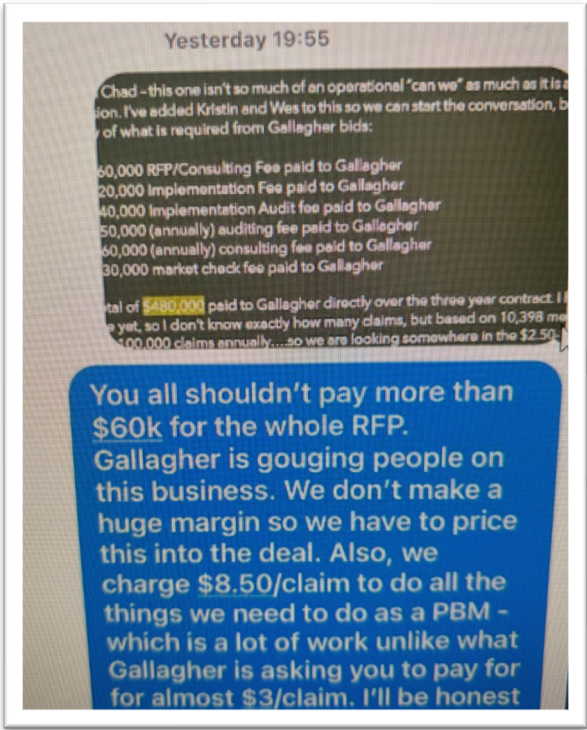
³ Id.

between the consultant and the PBMs being evaluated, the structure of the process itself can influence the outcome before a vendor is ultimately selected.

Example 5: Consultant-imposed fees incorporated into PBM pricing and their impact on market competition

In some cases, the financial arrangements described above are explicitly incorporated into the pricing submitted by PBMs during the procurement process.

As shown in Exhibit D, an email communication from a consultant, which has been screenshot in to a text exchange, outlines a series of required fees to be paid as part of participating in a PBM procurement, including RFP fees, implementation fees, audit fees, and ongoing consulting and market check fees. These payments total approximately \$480,000 over the course of the contract.



The response from a bidding PBM reflects how these requirements operate in practice. The PBM explains that it operates on relatively low margins, charging only \$8.50/per claim for the entirety of their PBM services. Therefore, when they “price this into the deal,” (i.e., another \$3.00 per claim), they note that they will likely look less competitive relative to other bidders.

This exchange illustrates how consultant-imposed fees can directly influence both pricing and participation in the market. Rather than reflecting only the cost of administering the pharmacy benefit or negotiating drug prices, the bid must also account for payments required as a condition of participation in the procurement. These types of requirements may have a disproportionate impact on PBMs that operate on a transparent or pass-through model, where margins are lower and pricing is more directly tied to actual administrative cost. For these entities, the need to

incorporate additional per-claim costs can materially affect their ability to compete on price. Compare this to those PBMs that generate revenue through a variety of other channels, as noted above.

From the employer's perspective, these effects may not be visible. The additional costs are embedded in the pricing, and the absence of certain bidders or pricing models may not be apparent. In this way, compensation structures tied to participation in PBM procurements can influence not only the cost of the benefit, but also which types of business models are able to enter and compete in the market.

Example 6: Oversight of PBM performance in the presence of financial relationships

In addition to the structural and contractual dynamics described above, the effectiveness of ongoing oversight can also be affected by financial relationships between consultants and PBMs.

Employers often rely on consultants to monitor PBM performance, review reporting, assess compliance with contractual terms, and advise on opportunities to improve cost and utilization outcomes. This oversight function is a central component of how plan sponsors fulfill their fiduciary responsibilities. At the same time, as described in earlier examples, consultants may have financial relationships with PBMs through a variety of arrangements, including per-claim payments, administrative credits, or broader commercial agreements. When the entity responsible for oversight is also receiving revenue from the entity being evaluated, this creates a structural tension. The same organization is positioned both to assess performance and to benefit, directly or indirectly, from the continuation or expansion of that relationship.

Consider the 100,000-life employer described above. Based on the structure in Exhibit C, claim-based payments from the PBM to the consultant could total approximately \$3.25 million annually, with an additional \$250,000 available through administrative credits, resulting in roughly \$3.5 million in annual payments tied to utilization. At the same time, PBM performance may be reported as meeting or exceeding contractual guarantees, including rebate guarantees and discount targets. From the employer's perspective, this may indicate that the arrangement is performing well. However, the underlying economics may tell a different story.

If utilization shifts toward higher-cost channels such as specialty pharmacy, mail-order, or 90-day dispensing, total claim volume in those categories increases. Under the structure described above, those same categories generate higher per-claim payments, including \$7.00 per claim for specialty, mail, and 90-day fills. As a result, a shift in utilization can increase payments flowing through the arrangement on multiple levels. Using the same example, if an additional 100,000 claims migrate into higher-credit categories, this would generate approximately \$700,000 in additional annual payments tied to those claims alone. At the same time, those claims are often associated with higher underlying drug costs.

In this scenario, the plan may continue to meet or exceed its contractual guarantees, while total cost increases and payments tied to utilization expand. The reported performance reflects compliance with the structure of the contract, but it does not necessarily reflect whether the lowest net cost outcome has been achieved.

Where financial relationships exist between the consultant and the PBM, these dynamics can also affect how performance is evaluated and communicated. The same factors that increase cost and utilization may also increase payments flowing through the arrangement, reinforcing the importance of independent oversight. From the employer's perspective, this creates a gap. The plan sponsor may receive reporting that indicates strong performance, while lacking the independent validation needed to assess whether the benefit is operating at the lowest net cost or in the best interest of plan participants. This dynamic reinforces the broader concern addressed by the PBM Kickback Prohibition Act. Where compensation is tied to PBM relationships, it can influence not only procurement and pricing, but also the effectiveness of ongoing oversight.

IV. Implications for Market Function and Fiduciary Oversight

The examples described above reflect a consistent pattern across the PBM market. Financial relationships between consultants, brokers, and PBMs can influence not only how prescription drug benefits are priced, but also how vendors are selected, how contracts are structured, and how performance is evaluated over time. These dynamics have direct implications for both cost and competition. Payments tied to participation in PBM arrangements can be incorporated into pricing, increasing the cost of the benefit in ways that may not be visible to the employer. At the same time, when participation in a procurement requires agreement to certain financial arrangements, or when compensation structures favor specific business models, some PBMs may be disadvantaged in their ability to compete. This can limit the range of options available to plan sponsors and reduce the likelihood that lower-cost or more transparent models are considered.

These issues are not theoretical and have been raised in multiple recent lawsuits involving large employers and benefit programs. In the Johnson & Johnson⁴ ERISA prescription drug litigation, plaintiffs alleged that the company's pharmacy benefit arrangements resulted in higher costs than necessary and questioned the role of advisors, including Aon, in structuring and evaluating those arrangements. Other litigation has raised similar concerns regarding broker and consultant compensation in areas such as voluntary benefits and pharmacy benefit management, including cases involving firms such as Gallagher.⁵ Additional cases have raised related concerns regarding pricing transparency and the ability of plan sponsors to independently evaluate the cost of services provided under complex benefit arrangements.⁶ In addition, lawsuits involving large employers,

⁴ *Lewandowski v. Johnson & Johnson, et al.*, No. 3:24-cv-00671 (D.N.J.) (ERISA fiduciary breach claims relating to PBM arrangements and prescription drug plan costs)

⁵ *Carfora v. Teachers Insurance and Annuity Association of America (TIAA), et al.*, No. 1:21-cv-08387 (S.D.N.Y.) (ERISA claims involving compensation structures, revenue sharing, and alleged conflicts of interest)

⁶ *Central Florida Employment Council, Inc. d/b/a Osceola County School Board Insurance Consortium v. Cigna Health and Life Insurance Company*, No. 6:23-cv-00691 (M.D. Fla.) (claims involving alleged overcharges, lack of pricing transparency, and inability of plan sponsor to independently evaluate costs)

including JPMorgan Chase,⁷ have focused on whether plan fiduciaries had sufficient visibility into fees, compensation structures, and service provider arrangements.

While the facts of each case are specific, these matters reflect a broader pattern. They underscore that even sophisticated employers with significant resources may face challenges in fully evaluating complex benefit arrangements, particularly where financial relationships and compensation structures are not fully transparent.

The impact extends beyond procurement and pricing to ongoing plan oversight. Employers rely on consultants to monitor PBM performance, evaluate compliance with contractual terms, and identify opportunities to improve cost and utilization outcomes. Where those same consultants have financial relationships with the PBMs they are evaluating, the independence of that oversight may be constrained.

As demonstrated, a plan may meet or exceed contractual guarantees while underlying costs increase or utilization shifts toward higher-cost channels. In these cases, reported performance reflects compliance with the structure of the contract, but may not fully capture whether the arrangement is operating at the lowest net cost or in the best interest of plan participants. Where incentives are tied to utilization or channel selection, these dynamics can compound over time. For plan sponsors, this creates a structural challenge. They are expected to act as fiduciaries under ERISA, yet may not have the information or independence necessary to fully evaluate pricing, vendor selection, or ongoing performance. Even sophisticated employers may be relying on advice and reporting that is influenced by financial relationships that are not fully visible.

These conditions affect how the market functions. They can increase costs, limit competition, and reduce the effectiveness of oversight, even in environments where formal procurement processes and contractual guarantees are in place.

V. Conclusion and Support for the PBM Kickback Prohibition Act

The PBM Kickback Prohibition Act directly addresses a core issue identified in these examples by prohibiting compensation arrangements that tie payments to the referral or placement of PBM business. By removing these financial connections, the legislation helps restore alignment between plan sponsors and the entities advising them.

This is a targeted and practical reform. It does not attempt to restructure the entire PBM market, but it addresses a specific and identifiable problem that affects procurement, pricing, and ongoing oversight. By limiting financial relationships that can influence recommendations, it supports more independent evaluation of PBM arrangements and a more level competitive environment. This

⁷ *Khan et al. v. Board of Directors of JPMorgan Chase & Co., et al.*, No. 1:22-cv-03814 (S.D.N.Y.) (ERISA fiduciary breach claims involving plan fees, vendor oversight, and failure to monitor service providers)

reform also supports existing fiduciary obligations under ERISA. Plan sponsors are required to act prudently and solely in the interest of plan participants. That responsibility depends on the ability to rely on independent advice and to evaluate both costs and incentives. Removing compensation structures that tie advisors to the placement of PBM business is a necessary step toward making that standard workable in practice.

To ensure the effectiveness of this approach, it will be important that implementation considers how compensation is structured across different arrangements, including those that operate at the level of a consultant's broader book of business. To the extent that these arrangements function as incentives tied to the placement of PBM business, they raise the same concerns described above.

For these reasons, I support the PBM Kickback Prohibition Act as an important step toward improving alignment, supporting competition, and enabling plan sponsors to meet their fiduciary obligations in a practical and meaningful way.