JAMES GELFAND
President and CEO

"Profits Over Patients: The PBM Business Model under Scrutiny"

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Introduction and About ERIC

Chairman Allen, Ranking Member DeSaulnier, and members of the Subcommittee, thank you for the opportunity to testify today on the pharmacy benefit manager (PBM) business model and its impact on America's largest employers and their employees. I'm James Gelfand, President and CEO of The ERISA Industry Committee (ERIC), the only national association that advocates exclusively for large employers on health, retirement, and compensation policies at the federal, state, and local levels. ERIC member companies are leaders in every sector of the economy, with employees in every state, and we represent them in their capacity as sponsors of employee benefit plans for their workforce.

Each of you and your constituents likely engage with an ERIC member company when you drive a car or fill it with gas, use a cell phone or a computer, visit a bank or hotel, fly on an airplane, watch TV, benefit from our national defense, go shopping, receive or send a package, visit a restaurant, or enjoy a soft drink.

Our member companies offer comprehensive health benefits to employees, their families, and often retirees. On average, large employers pay around 80 percent of health care costs on behalf of their beneficiaries. There are over 154 million people who receive coverage through employer-sponsored insurance and over 100 million of those receive coverage through ERISA self-insured plans.[1] All of this taken together means that the vast majority of Americans receive their health care coverage through employers, who shoulder exponential costs associated with the coverage they provide.

[1] KFF's analysis of data from the 2023 American Community Survey included in KFF's 2025 Employer Health Benefits Survey published October 22, 2025. See KFF. Health insurance coverage of the population ages 0–64 [Internet]. San Francisco (CA): KFF; [cited 2025 Sep 15]. [Time frame: 2023].

And these costs are not projected to abate – premium costs for employer-sponsored plans are now growing at a rate of six to seven percent each year.[2] For ERIC's member companies, some of whom provide coverage to over a million beneficiaries across the country, this translates into very real dollars – dollars that are not attributable to any revenue potential, but rather merely a loss on their books, which could have been otherwise realized as increases in wages and other employee benefits.

ERIC member companies provide health benefits to attract and retain employees, to compete for human capital, and to improve employees' health and provide peace of mind. They roll up their sleeves and invest in their employees and communities across the country, improving access to health care. Our
members are innovators who drive affordability and quality, through efforts such as the use of digital health, onsite clinics, and direct primary care arrangements for their workers. They develop value-driven and coordinated care programs, implement employee wellness programs, provide transparency tools, and a myriad of other innovations that improve quality and value to help mitigate health care costs.

We applaud Congress and the administration for advancing much needed transparency enhancements and policies to address anti-competitive practices in the employer-sponsored health benefit system. The *Consolidated Appropriations Act of 2026* (CAA26), as well as the administration's proposed improvements to the transparency in coverage rule, and the proposed transparency requirements regarding fees and compensation received by PBMs and their affiliates, including affiliated providers of brokerage and consultant services, are all positive steps toward greater accountability.

The PBM Business Model and Its Impact on Employer-Sponsored Coverage

Despite employers' aggressive efforts to innovate and control health care costs, PBM business models have become a significant barrier to affordability and transparency for prescription drugs. PBMs were originally intended to act as direct agents of plan sponsors, leveraging scale to negotiate against pharmaceutical companies for lower drug prices, reducing costs for health plans and patients. Today, however, that model has evolved into one characterized by consolidation, conflicts of interest, and opaque financial arrangements that too often misalign PBM incentives with the interests of plan sponsors and working families.

PBMs now exert substantial control over drug formularies, pharmacy networks, utilization management, and reimbursement rates, while simultaneously operating affiliated insurers, specialty pharmacies, mail-order pharmacies, and group purchasing organizations.

[2] Based on data comparison from Claxton, G., Rae, M., Damico, A., Winger, A., & Wager, E. (2025). Health benefits in 2025: Family premiums rise 6 percent, large employers increase coverage of GLP-1s for weight loss. *Health Affairs*, *44*(11). https://doi.org/10.1377/hlthaff.2025.01106

These vertically integrated structures allow PBMs to generate revenue through spread pricing, rebates, administrative fees, clawbacks, and other forms of compensation that are frequently hidden from employers. As a result, plan sponsors face rising drug costs without a clear understanding of where dollars are flowing or whether negotiated savings are actually reaching patients at the pharmacy counter.

For large, self-insured employers operating under ERISA, these practices directly undermine fiduciary responsibility. Employers are legally obligated to act in the best interest of plan participants, yet they are often denied access to the data necessary to evaluate PBM performance or to confirm that contractual promises are being fulfilled. This lack of transparency undermines employers' ability to manage costs effectively and fulfill their obligations.

The Role of PBM-Affiliated Group Purchasing Organizations (GPOs)

An increasingly important issue involves group purchasing organizations (GPOs) affiliated with PBMs. These GPOs negotiate, collect, and disburse manufacturer payments tied to preferred formulary placement for their affiliated PBMs, introducing yet another layer of financial complexity and opacity into the system.

These PBM-affiliated GPOs have emerged in recent years and are increasingly being used to exploit regulatory and contractual loopholes. Some of these entities—several of which are or were located outside of the United States—have effectively consolidated market power while operating in jurisdictions known for limited financial transparency and favorable tax treatment. These structures make it difficult for employers to understand where plan dollars are going and whether savings intended for patients and plan sponsors are instead being retained by intermediaries.

In practice, PBMs and their affiliated GPOs have employed what can fairly be described as a "labeling" or "shell game" to retain revenue that should otherwise flow back to employer health plans. When an employer contracts with a PBM requiring full rebate pass-through, the PBM may redirect manufacturer payments through its affiliated GPO. Once moved, those dollars are no longer labeled as "rebates," but instead reclassified as "GPO fees." Because many employer contracts refer narrowly to rebates, these newly labeled fees fall outside the employer's audit rights and contractual protections allowing PBMs to legally retain revenue that was effectively generated based on the plan's utilization.

This practice exploits technical distinctions rather than economic reality. These payments are functionally rebates, negotiated based on formulary placement and drug volume driven by employer-sponsored plans. Renaming them does not change their nature, but it does obscure them from plan sponsors and beneficiaries.

The scale and seriousness of these arrangements have drawn increased scrutiny. In 2024, the Federal Trade Commission launched enforcement actions against several of the largest PBMs and their affiliated GPOs, highlighting concerns about anti-competitive practices and artificially inflated drug costs.[3] These developments underscore the need for continued oversight and meaningful transparency across all PBM-affiliated entities—not just PBMs themselves.

ERIC believes the transparency provisions included in the CAA26 are an important step forward. CAA26 is designed to capture all fees, discounts, and remuneration paid to PBMs and their affiliates that must be fully passed through to the plan, permitting PBMs to retain only bona fide service fees for actual services rendered. Importantly, these requirements should bring greater visibility into so-called GPO fees and expose them for what they truly are.

At the same time, experience has shown that opaque intermediaries often adapt once transparency shines a light on existing practices—shifting structures, terminology, or entities in an effort to preserve revenue. The involvement of PBM-affiliated GPOs adds yet another profit-taking layer, and it is an area that warrants continued attention and oversight to ensure that savings intended for patients and employers are not diverted through new and increasingly complex arrangements.

The Role of Brokers and Consultants in PBM Selection and Management

Brokers and benefits consultants play influential roles in shaping employer decisions related to pharmacy benefits. These entities and professionals regularly advise employers on plan design and vendor selection, including PBM selection, formulary structures, and rebate arrangements. Brokers and consultants function as key intermediaries that shape purchasing decisions and contractual terms, giving them substantial influence over drug pricing and access.

Financial incentives embedded in these relationships can contribute to higher costs for employers and patients. Brokers and consultants may be compensated through commissions, administrative fees, or other forms of direct and indirect compensation connected to PBMs, which are sometimes tied to overall drug spending rather than net cost savings. It should be noted that Third Party Administrators (TPAs), essentially the PBMs for the medical and non-pharmacy parts of a group health plan, may similarly benefit from pricing practices such as spread pricing, retained rebates, or opaque fees. Together, these incentive structures can weaken pressure to prioritize the lowest net drug prices and encourage the use of higher-priced drugs that generate larger rebates. As a result, employers may experience higher premiums and plan expenses, while patients face increased cost sharing, narrower formularies, and reduced transparency around how prescription drug prices are determined.

[3] Abelson, Reed, and Rebecca Robbins. "F.T.C. Slams Middlemen for High Drug Prices, Reversing Hands-Off Approach." *The New York Times*, 9 July 2024.

In recent years, ERIC member companies have reported a number of anomalies related to these actors. Despite requirements in the *2021 Consolidated Appropriations Act* that brokers and consultants disclose their direct and indirect compensation, many have refused to report on compensation that they claim is not tied directly to a given plan sponsor. For instance, there are arrangements under which the consultant receives a payment from the PBM each time a prescription is filled by a plan beneficiary, or "retention bonuses" for a broker when a plan sponsor renews a contract with the same PBM or TPA. We believe this mass noncompliance masks conflicts of interest that raise costs for employers and patients.

We are also concerned about how these conflicts of interest may be shaping the management of the request for proposal (RFP) process for plan sponsors when they consider switching TPAs or PBMs.

There is widespread belief that financial incentives for brokers and consultants are shaping the structure of these RFPs in a way that precludes opportunities for smaller PBMs and TPAs, and that prevents meaningful apples-to-apples comparisons on the costs that will be borne by plan sponsors and beneficiaries. ERIC is interested in reform proposals to enforce fairness and a common baseline for RFPs that plan sponsors could adopt.

The U.S. Department of Labor issued a proposed rule that would require providers of PBM services and affiliated providers of brokerage and consulting services to disclose compensation to ERISA self-insured group health plan fiduciaries. The proposal implements the directive under an executive order from President Trump last February.[4]

Last week, ERIC praised the administration's efforts in its comments in response[5] to a proposed rule that would require these vendors and service providers to disclose information about their compensation to fiduciaries of self-insured, employer-sponsored health plans. The proposed rule incorporates many of the ERIC-led policy recommendations we have relayed to the administration and Congress and fosters greater transparency for employers and patients.

ERIC's comments also included several recommendations to build on the proposed rule requirements as well as those enacted as part of CAA26, including:

- Clarifying that all affiliated entities, such as GPOs and other service providers to group health plans, must disclose the compensation they receive.

[4] Executive Order No. 14156, 90 Fed. Reg. 24561 (2025).
[5] ERIC Comments in Response to "Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure
(RIN 1210-AB37) April 15, 2026."

- Listing specific examples of the types of compensation streams that must be reported, including payments flowing through vertically integrated arrangements, and "spread pricing" arrangements that flow through PBM-owned specialty pharmacies and PBM-owned "drug branding entities."

- Confirming that the prohibition on "gag clauses" that deny plan sponsors access to their own plan data cannot be undermined by TPAs or provider networks.

- Ensuring that a plan sponsor's audit rights apply to all functions the sponsor engages in to meet its fiduciary obligations.

- Recognizing that health claims data in a self-insured plan creates economic value for a service provider, and requiring the service provider to disclose that data to the plan fiduciary.

- Urging the Department to finalize the proposed requirements as soon as possible, while setting a January 1, 2027, effective date for the regulations, six months later than originally proposed.

ERIC believes that these recommendations align with the CAA reforms and fill in any potential gaps, such as addressing spread pricing.

The Need for the PBM Kickback Prohibition Act: Restoring Trust and Fairness in Employer Decision-Making

For most employers, the process of choosing a PBM is a practical decision that has a significant impact. As noted above, employers hire brokers and consultants because the system is complex, contracts are dense, and the stakes are high. These advisors are expected to serve as advocates for plan sponsors, helping employers navigate options, compare vendors, and make informed decisions in the best interests of workers and their families. Yet, too often, that trust is undermined.

Under current practices, PBMs may provide kickbacks or referral fees to brokers, consultants, or other intermediaries in exchange for steering employer-sponsored health plan business to a particular PBM. As a result, a plan sponsor may reasonably believe that a recommendation reflects independent analysis—when, in fact, it may be influenced by compensation flowing behind the scenes.

The *PBM Kickback Prohibition Act* (H.R. 7895), supported by more than 50 employer and patient organizations, addresses this problem directly and responsibly.[6]

[6] PBM Kickback Prohibition Act (H.R. 7895) Group Support Letter sent April 20, 2026.

By amending ERISA to prohibit PBMs from paying kickbacks or referral fees to intermediaries involved in PBM selection, the legislation focuses on a narrow but consequential source of conflicted decision-making without disrupting legitimate advisory services or market competition.

Employers of all sizes, in every industry, and in every state, rely on brokers and consultants to help them fulfill their fiduciary obligations. When advice is compromised by undisclosed financial incentives, everyone loses, patients pay more at the pharmacy counter, employers struggle to manage costs, and confidence in the system erodes.

As plan sponsors, employers should be able to trust that recommendations regarding PBM selection are based on value, quality, and the needs of plan participants, not on payments from vendors seeking business. Intermediaries who provide advice to ERISA plans should operate with undivided loyalty to their clients. When compensation flows from the vendors that they are supposed to evaluate, it undermines the integrity of that relationship and makes it harder for employers to make informed decisions on behalf of the plan.

This bill takes a clear and measured step to restore that integrity. By eliminating inappropriate financial incentives that distort decision-making, the legislation promotes transparency, accountability, and trust. It helps ensure that employers are choosing PBMs based on performance and value, free from the threat of hidden financial arrangements between the PBMs they are evaluating and the advisors acting on their behalf.

At a time when rising prescription drug costs continue to put pressure on employer-sponsored coverage, this legislation represents a practical reform that aligns incentives without overreach. It strengthens the employer-led system that covers the majority of Americans, supports fair competition, and helps ensure that decisions affecting patient access and affordability are made for the right reasons.

Additional Policy Solutions to Improve Transparency and Competition

Additionally, Congress has a critical opportunity to advance additional affordability reforms under the jurisdiction of this committee which would support working families' ability to access employer-sponsored health benefits, including:

- *Patients Deserve Price Tags Act* (H.R. 5582): Led by Congressman John James (R-MI) and Congresswoman Maggie Goodlander (D-NH), the bill provides for improved price transparency, helping patients understand the actual cost of care, and extends reporting requirements across a range of health care providers, plans, and PBMs. The real prices that will be available under this bill will help plan sponsors to discover where arbitrage is taking place, and help them design high-value provider networks to lower costs for patients.

- *PBM Fiduciary Accountability, Integrity, and Reform (FAIR) Act* (H.R. 6837): Led by Committee member Congressman Ryan Mackenzie (R-PA) and Congressman Jake Auchincloss (D-MA), the bill clarifies that fiduciary standards for ERISA employer health benefit plans apply in full to PBMs performing services on behalf of the plan. This would hold PBMs accountable to act in the best interest of the plan, doubling down on the reforms passed in CAA26.

- *Healthy Competition for Better Care Act* (H.R. 6248): Led by Budget Committee Chairman Jodey Arrington (R-TX) with committee member Congressman Rick Allen (R-GA) as an original cosponsor, this legislation would improve fairness in contracting by allowing for enrollee incentives to choose high-quality and low-cost providers, and allows insurers and employers to contract with hospitals and providers without requirements to enter into additional contracts with other affiliated providers or hospitals. This measure will ensure that plan sponsors can build their provider networks in a way that maximizes value for patients and excludes those sites of care where prices are inflated – including drug prices, as some hospital systems add unconscionable markups to drugs.

We encourage the Full Committee to hold a markup on these bills this year and support their enactment.

Furthermore, ERIC supports policies that address unnecessary costs for employers and patients, such as:

- RFP Reform
  Congress should consider policy changes to ensure that broker- and consultant-led RFP processes give a fair opportunity to a broad range of entities and are not designed to keep plan sponsors with a small set of vendors. Those RFPs should require some kind of baseline, bottom-line disclosures from RFP respondents that a plan sponsor can compare, apples-to-apples, to choose the lowest net effective costs for beneficiaries.

- Vertically Integrated GPOs and "Drug Companies"
  Congress should consider clarifying to the U.S. Departments of Health and Human Services and Labor that the language in CAA26 was intended to apply transparency to the entire PBM enterprise, including these affiliates. This should include revealing the "spread pricing" between what is paid to the manufacturer and what is retained by the PBM for "white label" drugs, as well as applying the rebate passthrough requirement to the various "fees" collected by the PBM's GPOs in lieu of rebates.

Conclusion

In closing, large employers share Congress's goal of lowering prescription drug costs and improving patient access. However, these objectives cannot be achieved without confronting the structural incentives and lack of transparency embedded in the current PBM business model. The PBM Kickback Prohibition Act and related reforms highlighted here represent critical steps toward restoring competition, aligning incentives, and ensuring that prescription drug savings flow to the patients and employers who ultimately bear the costs.

ERIC and its member companies stand ready to work with this Subcommittee to advance pragmatic, solutions to drive health care affordability for working families. By promoting transparency, accountability, and market competition, Congress can help ensure that employer-sponsored health coverage remains available, sustainable, and responsive to the needs of American across the country.