

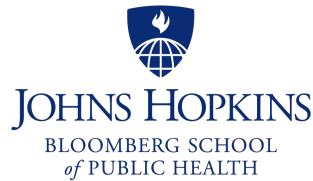
BEFORE THE U.S. CONGRESS
HOUSE COMMITTEE ON EDUCATION AND WORKFORCE
Subcommittee on Health, Employment, Labor and Pensions

Congressional Hearing

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

Statement of
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April 22, 2026



INTRODUCTION

Chairman Allen, Ranking Member DeSaulnier, and members of the Subcommittee, good morning. It is a great honor to be speaking with you today. I am Prof. Mariana Socal, an Associate Professor of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health based in Baltimore, Maryland. I am a medical doctor with a specialization in neurology. I have a Ph.D. in Health Systems from Johns Hopkins University and a master's in Public Policy from Princeton University. My research focuses on improving access and affordability for Americans who need prescription drugs to improve their health and quality of life.

For several years, I have been working with large employer organizations that are attempting to control prescription drug spending. These include ERIC-The ERISA Industry Committee, PBGH, the Purchaser Business Group on Health, and others. I have done extensive research examining the pharmacy benefits that self-insured employers – from school districts to America's largest corporations – offer to their workers.

I am speaking today on my own behalf. The opinions expressed herein are my own and do not necessarily reflect the views of Johns Hopkins University or Johns Hopkins Bloomberg School of Public Health. I would like to provide commentary on how high drug prices impact American commercial insurers and their beneficiaries, including self-insured employers, workers, and retirees.

1. HIGH COST OF PRESCRIPTION DRUGS WEIGHS HEAVILY ON COMMERCIAL INSURERS AND SELF-INSURED EMPLOYERS

Over half of all Americans obtain health coverage through their employer.¹ One third of all Americans are covered by employer self-sponsored health insurance plans.² This means that the prescription drug costs of most American workers are paid by employers and the workforce.³ Commercial health insurance including employer-sponsored and individual plans accounts for about 45% of all national prescription drug spending, exceeding Medicare (about 30%) and Medicaid (about 10%).⁴ On average, prescription drug costs consume over 15% of every dollar in private health insurance premiums.⁵

Commercial insurers bear most of the financial burden from prescription drugs, with higher spending growth among midsized employers

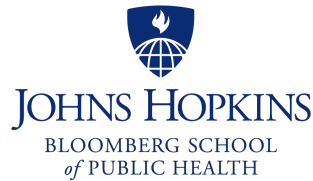
¹US Census Bureau - Health Insurance Coverage in the United States: 2018
<https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf>

² Kaiser Family Foundation Employer Health Survey 2018
<https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/>

³ Self-insured employers may purchase stoploss insurance, which may cover varying portions of the risk. (reference: Kaiser Family Foundation survey)

⁴ PMC, prescription drug spending by payer (MEPS 2017–2019 data) —
<https://pmc.ncbi.nlm.nih.gov/articles/PMC10835280/>

⁵ Peterson-KFF Health System Tracker, drug spending trends — <https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/>



A National Survey of Employer-Sponsored Health Plans found that pharmacy spending jumped 8.4% in 2023, following a 6.4% increase in 2022, making prescription drugs the fastest-growing component of employer health benefit costs. The average per-employee cost of employer-sponsored health insurance rose 5.2% in 2023 to reach \$15,797.⁶ Importantly, the highest cost increases were among smaller and mid-sized employers (50–499 employees), averaging 7.8%.⁷

In 2023, overall pharmaceutical spending grew 13.6% to \$722.5 billion/year. Specialty drugs including blockbuster drugs like Ozempic and Wegovy drove much of this increase.⁸ Three in four employers reported their benefit costs went up in 2023 due in part to increased pharmaceutical spending. Specialty drugs now account for over 50% of employers' total prescription spending.⁹

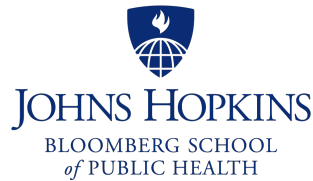
It is imperative to keep prescription drug spending under control in the commercial market

⁶ Source: Mercer, 2023 National Survey of Employer-Sponsored Health Plans — <https://www.mercer.com/en-us/about/newsroom/mercer-survey-finds-health-benefit-costs-up-5-2-percent-in-2023-due-to-inflation-and-higher-spending-on-prescription-drugs/>

⁷ Source: Mercer, 2023 National Survey of Employer-Sponsored Health Plans — <https://www.mercer.com/en-us/about/newsroom/mercer-survey-finds-health-benefit-costs-up-5-2-percent-in-2023-due-to-inflation-and-higher-spending-on-prescription-drugs/>

⁸ National Trends in Prescription Drug Expenditures and Projections for 2024 — <https://pubmed.ncbi.nlm.nih.gov/38656319/>

⁹ Marsh McLennan, The Impact of Rising Prescription Drug Costs on Employers — <https://www.marshmma.com/us/insights/details/health-care-economics.html>

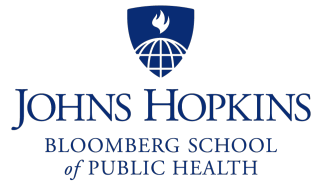


The increasing cost of prescription drugs has been driving trends in plans restricting access to prescription drugs through formulary exclusions and prior authorization requirements, and plans shifting more of the costs of prescription drugs onto beneficiaries. Today, many Americans cannot afford the drugs they need, even if they have health insurance, because of the high out-of-pocket costs that are associated with many drugs.

Reforms implemented by the Inflation Reduction Act of 2022 (IRA) have helped lower drug prices in Medicare, bringing much-needed relief to Medicare plans and beneficiaries. However, the commercial market was left out of such policies, and the high price of prescription drugs remains a big burden for both plans and patients in this sector.

2. PHARMACY BENEFIT MANAGERS PLAY A CRITICAL ROLE IN DETERMINING HEALTH PLANS' DRUG COVERAGE AND SPENDING

Commercial plans and self-insured employers typically hire a pharmacy benefit manager – PBM – to manage their drug benefit. The PBM negotiates prices with drug manufacturers and, based on these negotiations, designs the drug formulary that determines the drug benefit that the insurer will offer. Because the PBM determines which drugs are excluded and which ones are included in the formulary – and at which cost-sharing requirements for beneficiaries – the PBM plays a critical role in determining plans' pharmacy spending as well as beneficiaries' covered therapeutic options and associated out-of-pocket costs.



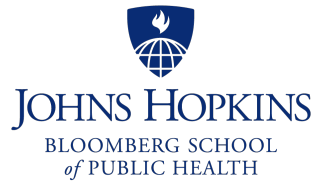
Vertical integration and lack of transparency challenge plans' ability to understand how PBMs impact pharmacy spending and beneficiary access

Today, 3 large PBMs collectively control 80 percent of the US market. These PBMs are: CVS Caremark, Express Scripts, and OptumRx.¹⁰ This enormous market concentration means that there is no real competition across PBMs. All the 3 large PBMs are vertically integrated with insurance plans, pharmacies, and health care providers.¹⁰ Some argue that those arrangements may increase efficiency and reduce costs. However, there is growing concern that the increasing vertical integration between PBMs, insurers, pharmacies, and providers in fact contributes to anti-competitive practices. This is one of the reasons why PBMs have been the focus of multiple investigations, including from Congress (such as the House of Representatives' Committee on Oversight and Government Reform¹¹) and government agencies (such as the Federal Trade Commission).¹² PBMs also have “no skin in the game” - they do not get penalized if patients cannot afford the drugs they need and need to use more medical care, increasing costs to insurers as a result.

¹⁰ <https://www.drugchannels.net/2025/04/mapping-vertical-integration-of.html>

¹¹ <https://oversight.house.gov/release/hearing-wrap-up-oversight-committee-exposes-how-pbms-undermine-patient-health-and-increase-drug-costs/#:~:text=The%20Oversight%20Committee%20obtained%20over%20140%2C000%20documents,patent%20c> are%20for%20their%20own%20financial%20benefit.

¹² <https://www.ftc.gov/news-events/news/press-releases/2025/01/ftc-releases-second-interim-staff-report-prescription-drug-middlemen>

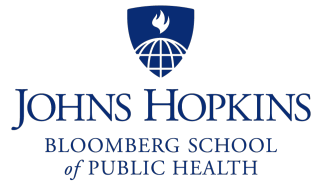


For commercial payers not integrated with a PBM, it is difficult to understand how PBM choices impact plan spending and patients' experience. PBMs characteristically limit the information that they share with plans. In my studies with self-insured employers, I've witnessed first-hand how employers were unable to obtain information from the PBMs with whom they contracted. One example was a software company that had developed the software that their PBM used to manage drug claims. This software company wanted to know how much they were spending on a certain drug. After initially declining to provide the information, the PBM proposed to provide this information for a \$5,000 fee.

My research on self-insured employers identified that the mix of drugs included in the formulary by PBMs often included "wasteful" drugs, i.e., drugs that cost more but provided the same benefit than lower-cost therapeutic options.¹³ One example of a wasteful drug is when a more expensive branded product is covered in the formulary instead of its cheaper generic. Although branded products have the same therapeutic benefit than generics, the more expensive branded product can offer greater rebates, which can in turn provide a greater opportunity for the PBM to keep a portion of the rebate as profit. We examined information from two large, self-insured employers and identified that removing wasteful drugs from the formulary and substituting them for lower-cost options with similar therapeutic value resulted in 15% net savings without beneficiary dissatisfaction.¹⁴

¹³ Removing Waste from Drug Formularies. <https://www.pbgh.org/wp-content/uploads/2021/01/PBGH-Wasteful-Drugs-Guidebook-FINAL.pdf>

¹⁴ Socal MP, Bai G, Cordeiro T, Anderson GF. Association Between Waste-Free Formularies and Prescription Drug Spending Among Self-insured Employers. *JAMA Netw Open*. 2021 Oct 1;4(10):e2131486.



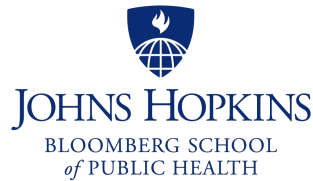
Without information, plans turn to brokers and consultants for help selecting a PBM – however, brokers and consultants often have conflicts of interest

Without sufficient information and with PBMs vertically integrated with insurers, it is difficult for health plans to select the right PBM. For non-integrated plans, it has become increasingly difficult to be able to select a PBM that does not choose drugs that will maximize their own profits and is transparent. For employers it is also difficult to select an insurer that is not tied to a specific PBM.

This is why plans usually hire consultants and brokers to help them select a PBM. A study published in the *American Journal of Managed Care* in 2024 surveyed 110 self-insured employer drug benefit decision-makers and found that benefit consultants were the most influential entity in PBM decisions: 37.3% of employers named a consultant as the primary driver. Benefits brokers were named by 21.8%, meaning consultants and brokers combined drive approximately 59% of PBM selection. HR/benefits leaders within the company accounted for 29.1% of the decisions according to this survey.¹⁵

The problem is that, in addition to being paid by the plan, consultants and brokers are often paid by the PBM that the plan ultimately selects. Investigations have documented that the 3 largest PBMs obtain much of their employer business through the major consulting houses, all of which earn over \$1.5 billion/year from benefits consulting and operate drug purchasing coalitions that channel employers

¹⁵ Henderson, Patterson, O'Brien. "Prescription Rebate Guarantees: Employer Insights." *Am J Manag Care*. 2024;30(11):574-580. PMID: 39546759



into contracts with the Big 3 PBMs.¹⁶ Ultimately, this can create an incentive for some brokers and consultants to prefer the PBM or insurer the pays them the most. Congress should not allow brokers to be paid by PBMs and insurers to avoid this conflict of interest.

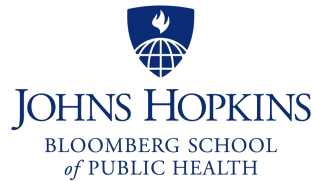
3. IMPROVED PBM REGULATION IS NEEDED BUT NOT ENOUGH FOR COMMERCIAL INSURERS AND SELF-INSURED EMPLOYERS

Recent reforms have tried to reign in some PBM practices and incentives that contribute to lower accountability to payors and higher prescription drug spending. Signed into law on February 3, 2026, the Consolidated Appropriations Act of 2026 included provisions to make PBMs more transparent – requiring PBMs to allow self-insured employer plans to audit PBM rebate records, including rebate contracts, and requiring PBMs to provide large, self-insured employer plans with detailed reports, among others.¹⁷ It also included provisions to reduce the incentives for PBMs to favor more expensive drugs instead of cheaper options - requiring PBMs to pass through all rebates to the plan sponsor in Medicare Part D and commercial markets, for example, and disconnecting PBM compensation from prices of drugs included in Medicare Part D formularies.

¹⁶ Axios — Bob Herman, September 2018

"How Big Consulting Firms and PBMs Work the Drug Pricing System"

¹⁷ H.R. 7148, Consolidated Appropriations Act, 2026, 119th Congress, Pub. L. 119-75, signed Feb. 3, 2026 — <https://www.congress.gov/bill/119th-congress/house-bill/7148>



Proposed regulation by the Department of Labor in January 2026 also aimed to expand transparency in self-insured employer markets, including by requiring the PBM to provide disclosure to a self-insured employer health plan of a series of expected compensation amounts *before* signing a contract.¹⁸

An important gap in recent PBM reform policies is that they do not modify the high prices that manufacturers charge for drugs

With the new regulations, employers will have more visibility into what they are paying — but the law does not compel lower drug prices. The current PBM business model incentivizes the use of big rebates, to which manufacturers have responded by raising list prices. For many patients, higher list prices mean higher out-of-pocket spending. Patients pay based on drug list prices when they are paying cash, are in the deductible phase, or are required by their insurer to pay a percentage of the drug cost (coinsurance) to get their drug.

A concern is that persistently high drug prices may incentivize PBMs to shift lost rebate revenue into higher flat administrative fees charged to plan sponsors, particularly since the legislation lacks a clear definition of "bona fide service fees" and "fair market value" in the commercial sector. This could increase not only patient cost-sharing but also health insurance premiums

¹⁸ Federal Register, 91 Fed. Reg. 4348 (Jan. 30, 2026) — <https://www.federalregister.gov/documents/2026/01/30/2026-01907/improving-transparency-into-pharmacy-benefit-manager-fee-disclosure>

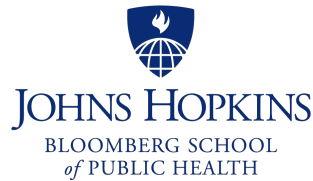
4. RECENT DRUG PRICING REFORMS HAVE BENEFITTED THE MEDICARE PROGRAM BUT NOT COMMERCIAL INSURERS AND SELF-INSURED EMPLOYERS

Different than the commercial insurance market, the Medicare program was the focus of a series of reforms to directly address high drug prices through the passage of the Inflation Reduction Act (IRA) in 2022. During 2022–2023, Medicare beneficiaries began receiving IRA protections — inflation rebates (Oct. 2022), \$35 out-of-pocket cap for insulin (Jan. 2023), and the first 10 drugs selected for price negotiation (Aug. 2023). Employers received none of these protections while their prescription drug costs surged 6.4% in 2022 and 8.4% in 2023.¹⁹

In Medicare, the drug price negotiation program achieved reductions of 38%–79% off list price for the 10 drugs selected in its first cycle (initial price applicability year 2026), with estimated savings to Medicare of about \$6 billion/year from these 10 drugs alone.²⁰ Medicare-negotiated Maximum Fair Prices (MFPs) are disclosed to the public, reducing the need for confidential rebates on these drugs. These transparent lower prices can now also serve as benchmarks for patient cost-sharing calculations, allowing Medicare beneficiaries to pay based on the lower negotiated price as opposed to the higher list price inflated by confidential rebates.

¹⁹ Mercer, 2023 employer survey — <https://www.mercer.com/en-us/about/newsroom/mercerc-survey-finds-health-benefit-costs-up-5-2-percent-in-2023-due-to-inflation-and-higher-spending-on-prescription-drugs/>

²⁰ <https://www.cms.gov/files/document/fact-sheet-negotiated-prices-initial-price-applicability-year-2026.pdf>



Maximum Fair Prices negotiated in Medicare should be available for commercial insurers and self-insured employers

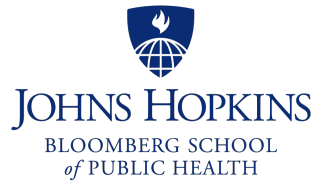
Two drugs that have been driving much of the growth in pharmacy spending for commercial insurers in recent years - Ozempic and Wegovy – have had their prices negotiated in the second cycle of the Medicare drug price negotiation program (initial price applicability year 2027), with the negotiated MFP representing a 71% discount off the drugs’ list price.²¹ However, as one analysis put it: *"A drug negotiated to a lower price for Medicare patients can still be sold at full commercial price to commercially insured patients. The vast majority of commercially insured patients remain in a pre-IRA pricing environment."*²²

In the commercial market, therefore, insurers pay significantly higher prices than Medicare, and beneficiaries do not have access to the transparent, lower MFP prices on which to base cost-share calculations. For a privately insured patient in a high-deductible health plan, not having access to the Medicare-negotiated MFPs would mean spending over \$900 every month for a 30-day supply of Ozempic when they could spend \$274 for this same drug under the MFP (starting 2027).

Medicare inflation rebate penalties should include commercial plans

²¹ <https://www.cms.gov/files/document/fact-sheet-negotiated-prices-ipay-2027.pdf>

²² DrugPatentWatch, IRA Price Reset analysis (2026) — <https://www.drugpatentwatch.com/blog/the-ira-price-reset-what-it-actually-does-to-pharma-pricing-and-what-comes-next/>



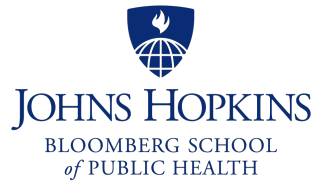
The Medicare inflation rebate penalties implemented by the IRA target drugs with price increases faster than inflation. This provision penalizes drug manufacturers increasing list prices faster than inflation by charging them a rebate, calculated as the difference between the actual price and an inflation-adjusted benchmark, multiplied by the total number of units sold in Medicare.²³

The inflation rebate penalty is not only intended to penalize, but also to deter drug list price increases. The US pays on average 3-4 higher prices for the same prescription drugs than other industrialized countries.²⁴ Older drugs that had been in the US market for several years had the largest price differentials. While list prices tend to go down in other countries over time, in the US list prices tend to only increase, even in the absence of modifications or innovations on the drug.

Given that commercial payors account for the largest share of pharmaceutical spending in the US, and that growing drug list prices contribute to higher costs in the commercial market, the inflation rebate penalty should also apply to the commercial market. This would mean, mainly, that the number of units of a drug that are sold in the commercial market should be included in the rebate penalty calculation together with the units sold in Medicare and that the price changes in commercial markets should be part of this calculation as well. Higher penalties from including commercial insurers in the Medicare inflation rebate penalty would serve as a larger deterrent to discourage drug list price increases.

²³ <https://www.cms.gov/files/document/rebate-report-frequently-asked-questions-mar2026.pdf>

²⁴ Kang SY, DiStefano M, Social MP, Anderson GF. Using External Reference Pricing In Medicare Part D To Reduce Drug Price Differentials With Other Countries. *Health Aff (Millwood)*. 2019 May;38(5):804-811.



In addition, it would provide savings in the commercial market. The Council on Informed Drug Spending Analysis (CIDSAs) of the West Health Policy Center conducted an analysis in 2022 estimating that spillover from the IRA's Medicare inflation rebate penalties would reduce employer-sponsored insurance costs by \$31 billion by 2031, of which \$24B in lower employer premiums, and \$8B in lower employee out-of-pocket costs.²⁵

Patient out-of-pocket protections should be expanded to commercial market

While the IRA has protected Medicare beneficiaries by implementing copay caps for insulin (maximum of \$35 out-of-pocket per 30-day supply) and an out-of-pocket maximum (\$2,000 per year), research by the Drug Channels Institute identified that nearly 1/3 of commercial plans lacked these maximum out of pocket caps, and a fifth of the plans had out-of-pocket maximums in excess of \$6,000 annually.²⁶ Congress should consider extending these protections out-of-pocket caps and out-of-pocket maximum protections to the commercial market.

The table below illustrates the difference between the drug price reduction measures implemented in Medicare and the gap that persists for the commercial market.

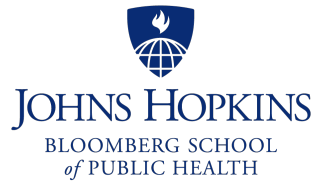
²⁵ <https://www.cidsa.org/publications/commercial-savings-generated-by-spillover-from-medicare-inflation-penalties-under-the-inflation-reduction-act-of-2022>

²⁶ [https://www.drugchannels.net/2023/01/the-state-of-employers-pharmacy.html#:~:text=Coinsurance%20amounts%20are%20typically%20based%20on%20the,had%20an%20OOP%20max%20greater%20than%20\\$6%2C000](https://www.drugchannels.net/2023/01/the-state-of-employers-pharmacy.html#:~:text=Coinsurance%20amounts%20are%20typically%20based%20on%20the,had%20an%20OOP%20max%20greater%20than%20$6%2C000)

Drug Pricing Reforms in Medicare vs. the Persisting Gaps in the Commercial Market

Metric	Medicare (IRA enacted)	Commercial / Self-Insured (excluded)
Price reduction achieved on negotiated drugs	38%–79% off list price (first cycle, initial price applicability year 2026)	No negotiated prices. Full commercial market price continues.
Estimated annual program savings	\$6 billion/year to Medicare (first cycle)	\$195B to employers + \$98B to workers by 2030 (H.R. 3 est., never enacted)
Inflation price cap protection	In effect from Oct. 2022 (Part D) & Jan. 2023 (Part B)	No equivalent protection. Employer drug costs grew 6.4% (2022) and 8.4% (2023).
Insulin cost cap	\$35/month for Medicare enrollees (Jan. 2023)	No federal cap. Commercial insulin prices remained unrestricted.
Out-of-pocket cap	\$2,000/year cap for Medicare Part D (effective 2025)	No federal out-of-pocket cap for employer plan enrollees.
10-year federal savings estimate	\$237 billion deficit reduction (CBO)	CMS Actuary estimated \$43B to businesses + \$120B to households under H.R. 3 — never enacted.
Who benefits	65+ million Medicare enrollees	160+ million Americans in employer plans — excluded by reconciliation ruling.

Initiatives such as H.R.6166, the Lowering Drug Costs for American Families Act could provide much-needed relief in the commercial market for both plans and beneficiaries



H.R.6166, the Lowering Drug Costs for American Families Act (2025-2026), would reduce prescription drug prices in the commercial market by expanding the Medicare drug negotiation program to include the commercial market and by applying inflation rebates to the commercial market. It proposes capping annual out-of-pocket prescription drug costs at \$2,000 for individuals and \$4,000 for families in private insurance, in addition to establishing a copay cap for insulin.²⁷

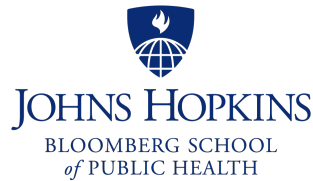
This legislation would extend the drug pricing reforms that have brought relief to the Medicare program to the commercial market. It would directly address the problem of high drug prices through price negotiations and the deterrent effect on rising drug prices from inflation rebates. The legislation would also benefit patients, who are directly harmed by high drug prices, through out-of-pocket maximums and copay caps.

CONCLUSION

The current PBM business model incentivizes the use of big rebates, to which drug manufacturers have responded by raising list prices. For many patients, higher list prices mean higher out-of-pocket spending. While the IRA has protected Medicare beneficiaries with out-of-pocket maximums and copay caps, nearly 1/3 of commercial plans lack out of pocket maximums.²⁸ Congress should consider extending out-of-pocket cap protections to the commercial market.

²⁷ <https://www.congress.gov/bill/119th-congress/house-bill/6166/text>

²⁸ [https://www.drugchannels.net/2023/01/the-state-of-employers-pharmacy.html#:~:text=Coinsurance%20amounts%20are%20typically%20based%20on%20the,had%20an%20OOP%20max%20greater%20than%20\\$6%2C000](https://www.drugchannels.net/2023/01/the-state-of-employers-pharmacy.html#:~:text=Coinsurance%20amounts%20are%20typically%20based%20on%20the,had%20an%20OOP%20max%20greater%20than%20$6%2C000)



Another way to counter the current PBM business model would be to provide transparent drug prices. Expanding the Medicare-negotiated MFP prices to the commercial market would allow commercial insurers and self-insured employers to access transparent, lower prices. This can reduce the contribution of rebates in coverage decisions, increase transparency, and lower overall costs. Lastly, to mitigate the increasing trend of drug companies raising list prices to maximize rebates when negotiating with PBMs, Congress could consider extending inflation rebates to commercial markets.

PBM reform is urgently needed throughout our health care system but in isolation it is not sufficient to provide the needed relief for commercial insurers and self-insured employers. High drug prices strain American employers, workers, and retirees. Because most Americans obtain health insurance through their employers, lowering prescription drug prices in the commercial market is imperative. This would not only help bring down premiums and out-of-pocket payments. Lower health care costs can also contribute to making American workers and American companies more competitive in the global market.

Thank you so much. I look forward to answering any questions that you may have.