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"Making Health Care Affordable: Solutions to Lower Costs and Empower Patients"

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I. Introduction: Transparency is the First Step Toward Accountability

Chairman Cassidy, Ranking Member Sanders, and Members of the Committee:

Thank you for the opportunity to testify on a matter that touches every American life and every American budget: the affordability of healthcare.

My name is Christin Deacon. I am a healthcare policy expert with a focus on employer and commercial market reform. I formerly served as Director of the State Health Benefits Plan for New Jersey, where I was responsible for coverage for over 820,000 public workers, retirees, and their families. I now counsel major labor-management health funds, including the 32BJ Health Fund, the Police Benevolence Association of New Jersey, various state employee health plan, large private-sector employers across the country, and nonprofit purchaser coalitions that represent tens of millions of commercial lives. I have testified before multiple state legislatures and am frequently called upon by federal and state agencies to lend expertise on the employer-sponsored insurance market.

In my work, I have seen firsthand what employers, state governments, and working families face: healthcare costs that rise faster than wages, premiums that outpace inflation, and a payment system where neither the purchaser nor the patient can see where the money is going. Transparency is not a talking point. It is a prerequisite to affordability, competition, and accountability.

Without transparency, we cannot see the drivers of cost. We cannot see how financial incentives are misaligned. We cannot see which entities are extracting value and which are delivering it. And because we can't see it, we can't fix it.

Transparency is the throughline of this testimony—not just as a principle, but as the starting point for any serious effort to lower healthcare costs and realign incentives. This testimony outlines how systemic opacity across hospital pricing, claims data, pharmacy benefit design, and the 340B program undermines employer oversight, distorts spending, and demands urgent congressional action to restore transparency, accountability, and affordability in the commercial health care market.

II. Transparency Isn't a Niche Reform. It's the Foundation.

Hospital Price Transparency

Price opacity in healthcare is not a bug in the system — it is the system. The current structure relies on withholding critical pricing information from employers, patients, and even policymakers. This lack of transparency enables dominant market participants to dictate prices, control access, and avoid accountability. The justification often cited — that transparency would be anticompetitive or compromise proprietary information — simply doesn't hold up. No other major consumer-facing industry is permitted to operate with such sustained, systemic price secrecy, especially when individual patients and public institutions are footing the bill.

In healthcare, the absence of pricing transparency is not incidental. It has been a deliberate strategy that allows intermediaries to negotiate rates in private, steer utilization in ways that maximize revenue, and shield the true cost and value of services from those paying for them.

Let's be clear about who those funders are. Government is the largest payer of healthcare in this country. Federal and state governments together account for roughly 50% of all U.S. healthcare spending.[i] In 2023, total U.S. healthcare spending reached $4.7 trillion, with Medicare and Medicaid accounting for more than $1.8 trillion of that amount.[ii] Employer-sponsored insurance is subsidized through the federal tax code at a cost of more than $300 billion annually in forgone tax revenue.[iii] And the Affordable Care Act's marketplace subsidies cost approximately $90 billion per year and are projected to rise.[iv] Public employers—school districts, state and local governments—contribute hundreds of billions annually for employee health coverage. This is not a private negotiation between two businesses.[v] This is a publicly subsidized, consumer-funded system that hides prices from the very people who pay.

Hospital price transparency rules, finalized by the Centers for Medicare & Medicaid Services (CMS) and effective January 1, 2021, were intended to address one of the most fundamental breakdowns in healthcare markets: the inability of purchasers to know, compare, or evaluate prices. The regulation requires hospitals to publicly post both their gross charges and payer-specific negotiated rates for all services, enabling patients and purchasers to better understand what they are being charged and what others are paying.

But more than three years into implementation, compliance remains poor. A 2024 study by PatientRightsAdvocate.org found that just 36% of hospitals were fully compliant with the federal rule. Many hospitals continue to post incomplete files, suppress negotiated rates, or fail to make the data available in a machine-readable format. Others use complex billing codes or unsearchable PDFs, undermining the rule's intent of enabling apples-to-apples price comparisons. This lack of compliance is not due to ambiguity. CMS has issued detailed technical guidance and offered multiple rounds of clarification.[vi] Yet enforcement has been limited. As of mid-2025, fewer than 30 hospitals have been fined, despite thousands of violations documented by independent audits. The penalties—often less than the revenue hospitals earn from a single high-margin commercial admission—are not meaningful deterrents.

The practical result is that employers, unions, and state purchasers cannot reliably compare prices across providers or evaluate whether their networks are delivering competitive value. When a hospital in one ZIP code charges $6,000 for a colonoscopy and a hospital 10 miles away charges $1,200—but neither posts usable data—there is no way for purchasers to intervene, steer volume, or hold plans accountable for network adequacy and cost-efficiency. The Hospital Price Transparency rule was not a radical policy**.** It simply required hospitals—entities that receive billions in taxpayer funding through Medicare, Medicaid, 340B, and tax exemption—to disclose the prices they have already negotiated with insurers. Price transparency is not just about consumer choice. It is the baseline requirement for any form of accountability. Without it, employers cannot verify prices paid, regulators cannot assess market fairness, and patients remain blindfolded in one of the most expensive transactions of their lives.

To restore the utility of this rule, enforcement must match the policy's intent. CMS should levy meaningful fines for noncompliance, publish an accessible database of violators, and hospitals that fail to comply should face conditions on their participation in other federal funding programs—including Medicare, Medicaid, and 340B.

If healthcare is to be a market, it must start by meeting the most basic condition of a functioning market: visible pricing.

Transparency in Coverage

The federal Transparency in Coverage (TiC) rule was designed to give plan sponsors—including self-funded employers—access to the negotiated prices, allowed amounts, and prescription drug costs they have historically been denied. Issuers and third-party administrators (TPAs) are required to post machine-readable files (MRFs) containing negotiated in-network rates and historical out-of-network allowed amounts, updated monthly. While the rule represents a meaningful policy shift, its real-world utility remains limited. The machine-readable files are enormous, often containing tens of millions of lines of data, with no standardized schema across issuers. As the Purchasers Business Group on Health (PBGH) and other stakeholders have noted, the variation in file structure, nomenclature, and formatting makes it extremely difficult—if not impossible—for most employers to extract actionable insights.[vii] Moreover, because the TiC data is not aligned with the Hospital Price Transparency rule, employers' ability to compare plan-reported negotiated rates with hospital-posted payer-specific charges to verify accuracy or assess network performance has remained elusive. Even sophisticated analytics firms face difficulty reconciling data across the two sources due to inconsistent use of billing codes, naming conventions, and the absence of claim-level context.

Critically, there is no audit mechanism in place to validate the completeness or accuracy of TiC submissions. No federal process currently exists to ensure that issuers and TPAs are reporting all required rates, nor are there meaningful penalties for noncompliance.[viii] For plan sponsors subject to ERISA fiduciary duties, this creates a disconnect: they are expected to monitor plan performance but are denied access to reliable, usable tools to do so. To be effective, the TiC rule must be accompanied by data standardization requirements, enforcement protocols, and mechanisms to align plan-level transparency with provider-level price disclosures.

The Need for More Systemic Transparency

The Hospital Price Transparency and TiC rules have laid a critical foundation. By requiring hospitals and health plans to publish negotiated rates, these policies have created the first meaningful opportunity for purchasers, researchers, and policymakers to quantify price variation and benchmark performance. These were and are important and necessary steps—designed to

bring long-overdue visibility to a healthcare system long shielded from scrutiny. But they are not sufficient on their own.

To manage spending, improve quality, and fulfill fiduciary duties, plan sponsors need more than price data alone. They need system-level transparency: insight into who owns what, who profits from each transaction, and how those financial relationships shape costs and care delivery. Today, those connections remain largely hidden—masked by vertical integration, opaque revenue sharing, and contractual silos that limit accountability. What looks like a negotiation between independent payers and providers is, in many cases, a negotiation between subsidiaries of the same vertically integrated conglomerate. When hospitals, insurers, PBMs, pharmacies, and physician groups are all owned by a single corporate entity, the very premise of a competitive market breaks down. Real reform must address not just prices—but the structure of the market itself. Transparency must evolve from a compliance exercise into a functional tool for oversight, competition, and decision-making.

Consider the current structure of the market: what appear to be separate companies negotiating at arm's length are often subsidiaries of the same corporate parent.

- UnitedHealth Group owns UnitedHealthcare (payer), OptumRx (PBM), Optum Specialty Pharmacy, and Optum Health, now the nation's largest employer of physicians with over 90,000 under direct or affiliated control. It also owns Change Healthcare, which processes roughly 1 in every 3 healthcare financial transactions in the U.S.—amounting to over $2 trillion in value annually. Over half of UnitedHealth's total revenue now flows through its Optum division, not insurance.[ix]

- The Cigna Group owns Cigna (payer), Express Scripts (PBM), and Accredo (specialty pharmacy). Cigna's PBM operations are vertically structured through Ascent Health Services, a Switzerland-domiciled GPO and rebate aggregator. This arrangement allows significant manufacturer rebate flows to be routed offshore—beyond regulatory and purchaser oversight—and shared among Cigna's affiliated entities. A 2024 report revealed that the top three PBMs retain more than $50 billion in rebates and fees annually that are never disclosed to employers or patients.[x]

- CVS Health owns Aetna (payer), Caremark (PBM), CVS Specialty Pharmacy, and also many provider entities. It also operates Wellpartner, a 340B third-party administrator (TPA), and controls contract pharmacy arrangements that generate substantial profits from prescriptions bought at steep discounts intended for low-income patients. According to the 2025 Senate Majority Staff Report, CVS retains an average of 13% of commercial reimbursement as a contract pharmacy fee under 340B. Additionally, its TPA business earned $382 million in administrative fees in 2023 alone.[xi]

These arrangements are not transparent. They are engineered to obscure cost, ownership, and accountability. Patients and employers see a "preferred" drug or "in-network" provider without any insight into how those designations were determined—or who profits from them.

Transparency in pricing, ownership, rebate flows, and conflicts of interest is the only way to reveal the extent of self-dealing that occurs within these structures. Whether it's a $5,000 specialty drug purchased for $1,250 under 340B and sold at full price to a patient, or a GPO routing manufacturer rebates through offshore entities, the result is the same: profits maximized at the expense of affordability and fairness. Profit-seeking is expected in any corporate structure — but in healthcare, it's occurring in a system that lacks the most basic market safeguards: transparency, competition, and accountability. That's not a functioning market. It's institutionalized arbitrage, hidden from the people who fund it.

While much of the focus is placed on costs to employer plans, taxpayers and public programs, it is ultimately the consumer who bears an increasing share of the cost of healthcare in the commercial market. Over the past decade, average deductibles for employer-sponsored insurance have risen by more than 300%.[xii] At the same time, coinsurance — which exposes patients to a percentage of unknown prices — has increasingly replaced flat-dollar copayments, shifting even more financial risk to individuals.[xiii] According to KFF's 2023 Employer Health Benefits Survey, nearly half of all covered workers are now enrolled in plans with coinsurance for hospital or specialist services, and 29% face coinsurance even for generic prescription drugs.

Despite this increased cost burden, consumers are routinely expected to "shop" for healthcare like they would for groceries or airline tickets — yet they are navigating a market devoid of visible

prices and dominated by vertically integrated entities that often steer choices toward financially affiliated providers, pharmacies, and products.[xiv] This is not a functioning consumer market. It is a system that is increasingly externalizing financial risk onto patients while insulating intermediaries.

III. Employers Fund the System—But Are Denied the Tools to Fix It

My testimony is shaped by a particular focus: the self-funded employer market. After leading one of the largest public health plans in the country—covering over 820,000 public workers and retirees—I have spent the better part of the last decade advising both public and private purchasers. This includes labor-management funds, state and municipal governments, and large self-funded employers. In every one of those engagements, one issue persists: a total lack of access to usable, comprehensive, and timely claims data.

In the self-funded model, employers bear the financial risk and directly pay the claims—but they almost always contract with a large insurance carrier to serve as a third-party administrator (TPA). These TPAs manage the provider networks, adjudicate claims, and often manage the pharmacy benefit or subcontract it to a PBM. Yet despite funding the plan and assuming the financial risk, employers are routinely denied access to the very data they need to manage that risk effectively. Without this information, they cannot validate payments, audit performance, or understand what they are truly purchasing on behalf of their employees.

Today, there should exist three primary pillars essential to functional market participation in healthcare:

1. Hospital Price Transparency Data, required under federal rule, is intended to show the *negotiated rates* that hospitals have agreed to accept from different payers for specific services — a view of the "price on the menu."
2. Transparency in Coverage Files, required of insurers and third-party administrators, are designed to disclose *what was negotiated on the employer's behalf* — allowing plan sponsors to compare in-network rates, evaluate network adequacy, and understand the relative competitiveness of their contracts.

3. Access to Claims and Payment Data, the third and most essential pillar, allows employers to see *what is actually being paid* — not just the contracted rate, but the full financial transaction: the amount billed, the amount allowed, and the actual amount paid from the plan's assets.

This final element—access to complete, plan-level claims data—is indispensable yet remains one of the most underappreciated and misunderstood pillars of healthcare transparency.

Claims data is, in essence, the employer's equivalent of a receipt. It captures what services were delivered, when and where they were provided, who performed them, and how much was charged, allowed, and paid—including patient cost-sharing. These records are formatted using standardized medical and billing codes (like CPT, DRG, and NDC), enabling plans to evaluate utilization, compare provider performance, detect fraud, and assess value. Without this level of payment transparency, price transparency is incomplete. Seeing the "list price" for a service is informative—but unless employers can reconcile that price against the actual amounts withdrawn from their plan assets, they cannot validate discounts, audit performance, or fulfill fiduciary oversight obligations. In practical terms, claims data is not a luxury—it is the ledger of the transaction.

This systemic opacity prevents employers from exercising their market power — and instead places them in the position of funding a system they are functionally barred from overseeing. Employers provide health coverage for over 165 million Americans, making them the largest source of private health care spending in the U.S. As costs soar—projected to exceed $35,000 per family in 2025—employers are expected to serve as the primary check on price and quality on behalf of their workers and families. The purchasing power of employers is one of the few remaining forces capable of restoring discipline to healthcare markets—but only if they are given the tools, data, and regulatory support to wield it effectively.

Despite statutory protections under Section 201 of the Consolidated Appropriations Act of 2021 (CAA), most employers remain unable to access the claims data they need to oversee their health plans. A key reason is the continued use of gag clauses—contractual provisions that prevent plan sponsors from accessing or sharing critical information about prices, payments, and provider

performance. Congress prohibited such clauses in the CAA to ensure that employers, as fiduciaries, could obtain deidentified claims data and share it with third parties for analysis and oversight. Yet in practice, these clauses persist—either explicitly or through evasive contractual workarounds.

For example, some carriers have offered narrow "confirmations of compliance" stating that gag clauses have been removed from their provider contracts; while leaving data restrictions in the administrative services agreements (ASAs) they hold with employer clients.[xv] Others have argued—publicly and in court filings—that Section 201 applies only to group health plans and imposes no obligations on service providers themselves. In other instances, TPAs have removed the offending language from main contracts, only to reintroduce it in nondisclosure or data use agreements downstream, effectively nullifying the transparency provisions.[xvi] Some employers have been told they cannot access allowed amounts unless they agree to use the carrier's own analytics vendor, contrary to their right under the law to choose their own business associate. In many cases, even when data is made available, it is incomplete, heavily aggregated, or delivered in unusable formats—making it impossible to reconcile with Transparency in Coverage or hospital price transparency data, let alone validate payments or assess value.[xvii]

These are not fringe anecdotes. This is how the majority of large employers are forced to operate within the confines of self-funded TPA agreements today.[xviii]

Consider the following examples of standard contractual language in national ASO agreements:

> "PROPRIETARY INFORMATION AND CONFIDENTIAL INFORMATION...Anthem's Proprietary Information is non-public, trade secret, commercially valuable, or competitively sensitive information, or other material and information relating to the products, business, or activities of Anthem or an Anthem Affiliate, including but not limited to: (1) Information about Anthem's Provider networks, Provider negotiated fees, Provider discounts, and Provider contract terms; (2) information about the systems, procedures, methodologies, and practices used by Anthem and Anthem Affiliates in performing their services such as underwriting, Claims processing, Claims payment, and health care management activities; and (3) combinations of data elements that could enable information of this kind to be derived or calculated..."

Administrative Services Agreement, Owens & Minor vs. Anthem, Case No. *from Owens & Minor vs. Anthem, Case No. 3:23-cv-00115,*

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Confidential Information: Includes without limitation the following, regardless of form or the manner in which it is furnished: (a) pricing, discounts, reimbursement terms, payment methodologies and payment processes, compensation arrangements and any similar commercial information ("Rate Information") and (b) data, information, statistics, trade secrets and any information about business, costs, operations, techniques, know-how or intellectual property. Any material that is derived from or developed from Confidential Information will be deemed Confidential Information for purposes of this Agreement, regardless of the person creating, disclosing or making available such material. Any Confidential Information included in preparations, proposals, scope documents, discussions, findings, summaries, reports and conclusions remains Confidential Information.

Administrative Services Agreement ("Agreement") between UMR, Inc. and City of Joplin, MO ("Customer") is effective January 1, 2021 ("Effective Date")
https://www.joplinmo.org/AgendaCenter/ViewFile/Item/6432?fileID=34097

In response to a routine request for line-item claims detail—including actual allowed amounts paid to providers—one employer received this reply from its TPA:

From: Turner, Hannah <hannah.turner@anthem.com>
Sent: Monday, February 21, 2022 4:58 PM
To: Boykin, Timothy <Timothy.Boykin@owens-minor.com>
Cc: Jones, Chloe <Chloe.Jones@owens-minor.com>; Taylor, Charles J. <charles.taylor@anthem.com>
Subject: [EXTERNAL] RE: OMI Anthem Data Request - Medical

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe. If you question any part of this email, please forward to Phishing@Owens-Minor.com

Hi Tim and a late Happy New Year! – Thanks for your outreach. I'm happy to have our data team leaders review this request. Out of the gate, I will say that we won't release both allowed and paid/billed. This would expose our confidential discounts/payment contracts aligned to each provider. Are you comfortable removing one of those before I submit to our team for review? If yes, which would you be willing to remove?

Thanks,
Hannah
Anthem, Inc.
Hannah R. Turner, *Client Executive, National Accounts*

(Excerpt from Owens & Minor vs. Anthem, Case No. 3:23-cv-00115, page 52)

Let's be clear. These elements of a claim - "allowed, paid/billed" - are not trade secrets between two competitors. These are claims paid with employer and employee dollars—often taxpayer dollars—managed by third-party administrators under contracts paid for by the employer. And yet, the employer is told it cannot see the financial details of its own plan.

So, what is being hidden? The fields identified in the email above, otherwise known as line-level claims data — would allow an employer or fiduciary to derive and evaluate multiple critical financial, contractual, and performance metrics that are otherwise hidden. Access to the billed, allowed, and paid amounts would specifically allow the plan sponsors to determine the actual price paid for services, assess discount levels, compare contracted rates across providers, verify member cost-sharing accuracy, identify overpayments or waste, evaluate rebate and 340B pharmacy opportunities, analyze network performance and steerage effectiveness — and critically, uncover hidden fees or spreads embedded in the claims flow.

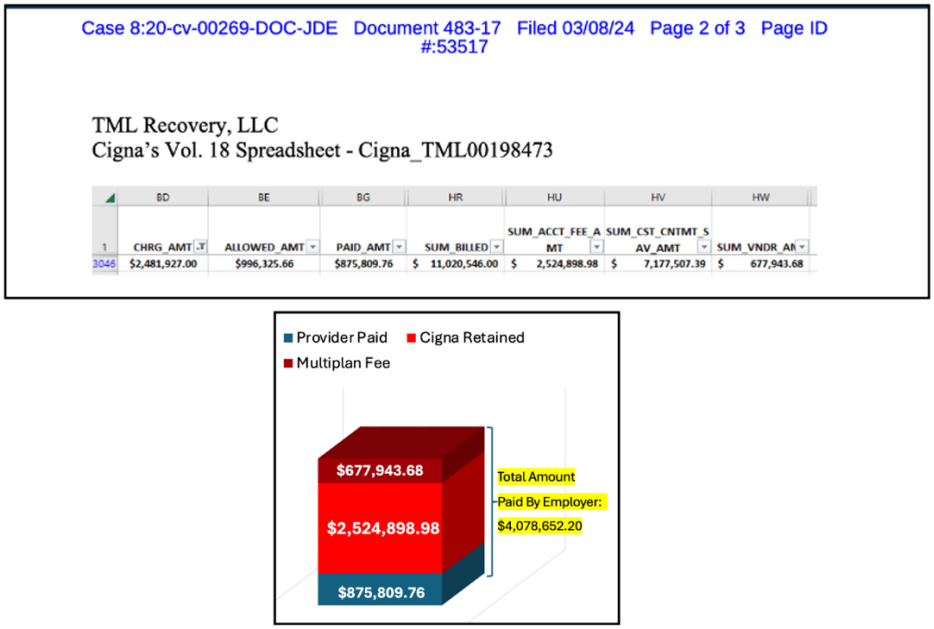
Example 1: Identifying Administrative Fees and Intermediary Charges Through Claims Data

Access to billed, allowed, and paid amounts enables employers to identify not only the true price of care, but also the administrative layers and financial intermediaries embedded in the claims process — entities whose costs are often invisible in aggregate reporting. One of the clearest examples of this is the use of repricing and "negotiation" vendors such as MultiPlan, Viant and others, which are routinely engaged by third-party administrators (TPAs) to manage out-of-network claims or "cost containment" services. Their involvement often results in significant administrative charges that bear no relationship to the value of care delivered — and can only be detected when line-level claims data is analyzed.

In one such case involving Cigna and Multiplan, a single high-cost out-of-network claim was processed through these intermediary layers. The actual amount paid to the medical provider was ultimately $875,809.76. However, the total amount paid by the health plan was $4,078,652.20.

Of the difference:

- Cigna retained $2,524,898.98 in administrative and other fees;
- Multiplan retained $677,943.68, based on its repricing agreement.



This means that over $3.2 million—approximately 79% of the total cost to the employer—was paid to non-clinical entities. These funds were not associated with the delivery of healthcare services, but rather with administrative overhead resulting from opaque third-party contracting arrangements.

This case highlights the financial opacity endemic to current self-funded plan administration arrangements. Without access to complete, unredacted claims data, including all financial and administrative fee fields, employers are unable to identify, contest, or prevent such outcomes. Many are unaware that these types of financial extractions are occurring at all, because they are hidden behind redacted reports, "proprietary" pricing logic, and layers of delegated service arrangements.

Example 2: Identifying Overpayments and Inappropriate Billing Practices

Access to full claims data also enables employers to uncover inappropriate billing practices that artificially inflate allowed amounts and misrepresent plan performance. One such practice, revealed in *Tiara Yachts, LLC v. Blue Cross Blue Shield of Michigan*, involved the use of so-called "flip logic"—a process by which out-of-network claims were reclassified and reported as in-

network triggering substantially higher payment rates that were not consistent with plan documents.

For example, a claim for a $1,500 billed amount was allowed in full, despite the national average for the same service being just $51.01—an effective reimbursement rate of nearly 3,000% of the average. Other claims showed similarly inflated allowed amounts: $6,400 for a service with a $3,600 national benchmark, and $16,500 for one averaging $4,450.

The below chart illustrates a sample of claims subjected to FLIP LOGIC that were identified in the document labeled BCBS COMAU-00027429, this validates that these claims are in fact out-of-network and show up as in-network.

Claim #	Date Incurred	Total Billed	Total Allowed	National Average (for all services)	% of National Avg.
[redacted]	[redacted]2018	$6,400	$6,400	$3,600	178%
[redacted]	[redacted]2018	$1,500	$1,500	$51.01	2,941%
[redacted]	[redacted]2017	$18,500	$16,500*	$4,450	371%
[redacted]	[redacted]2015	$2,638	$2,638	$196	1,345%

*$2,000 diff. represents service line denied in whole. 100% of billed allowed across all other service lines

Exhibit G to Tiara Yachts Complaint Case 2:19-cv-12623-BAF-CI ECF

Without access to detailed claims data and the ability to audit how claims are adjudicated and labeled, employers remain blind to these practices. The implications are significant—not only for financial integrity, but for network management, benchmarking, and fiduciary compliance.

Example 3: When Lack of Claims Data Prevents Oversight of Network Contracting and Tiering Decisions

The consequences of employer data blindness extend beyond payment discrepancies — they can also mask restrictive contract terms that limit plan design flexibility and block cost-saving interventions. Without access to complete, line-level claims data, employers cannot evaluate whether high-cost providers are driving unnecessary spend, whether alternative providers offer

better value, or whether their network contracts are being used to steer volume toward entrenched monopolies.

This dynamic was brought into sharp relief just days ago, when *The New York Times* reported that the U.S. Department of Justice had launched a civil antitrust investigation into New York-Presbyterian Health System.[xix] The case centers on allegations that the system engaged in secretive network contracting practices that prevented plan sponsors from steering patients to lower-cost alternatives — a restriction that, if true, would have remained entirely invisible without access to claims and utilization data. The investigation stems from a complaint filed by the 32BJ Health Fund. According to internal documents, the fund's third-party administrator, claimed it could not alter tiering or exclude New York-Presbyterian from the network due to pre-existing contractual terms — terms the employer neither negotiated nor approved, and likely could not review.[xx] This is not a theoretical concern. It is a live federal investigation into precisely the type of anti-competitive contracting that thrives when plan sponsors lack the data necessary to see where their dollars are going, identify misaligned incentives, and intervene in their own plan's financial and structural performance.

These cases highlight the financial opacity endemic to current self-funded plan administration arrangements. Without access to complete, unredacted claims data, including all financial and administrative fee fields, employers are unable to identify, contest, or prevent such outcomes. Many are unaware that these types of financial extractions are occurring at all, because they are hidden behind redacted reports, "proprietary" pricing logic, and layers of delegated service arrangements.

The broader implication is clear: in the absence of transparent data and direct oversight of vendor contracting, self-funded employers cannot adequately fulfill their fiduciary responsibilities, evaluate plan performance, or understand the actual drivers of healthcare costs. The Department of Labor's 2021 and 2023 guidance makes clear that ERISA plan fiduciaries must monitor compensation paid to service providers, ensure reasonableness, and act in the best interest of plan participants. None of this is possible without claims-level financial data and pharmacy rebate disclosures.

The scale of the opacity facing employer-sponsored plans has also been substantiated and well-documented by the Federal Trade Commission. A 2023 FTC report found that the three largest PBMs retain tens of billions of dollars annually in manufacturer rebates, fees, and revenue-sharing arrangements — much of it hidden from the employers and plan sponsors that ultimately fund the benefit.[xxi] Similarly, employer surveys and coalition research have shown that many self-funded plans do not receive full access to line-level claims data or a complete accounting of pricing concessions tied to their pharmacy benefit.[xxii] Even under so-called "pass-through" contracts, PBMs may retain revenue through affiliated entities, such as rebate aggregators or group purchasing organizations, in ways that are undisclosed and untraceable to the plan sponsor.[xxiii] These practices erode fiduciary oversight and deny employers the tools they need to manage spend and ensure accountability.

To reclaim market power, employers must have access to at least three categories of information: actual prices paid to providers; plan-specific formulary and rebate arrangements, and comprehensive claims data at the line level, with financial fields intact. Without this, purchasers are flying blind. They cannot assess value. They cannot identify waste. They cannot steer patients to higher-value providers. And they cannot fulfill their legal and fiduciary obligations. No amount of benefit design ingenuity or consultant analysis can compensate for a total absence of data. We must ensure that employers are not just check-writers—but informed, empowered purchasers who can see where their dollars go, and act accordingly.

IV. The PBM Shell Game: Misaligned Incentives, Opaque Rebates, and Dangerous Consequences

For employer-sponsored health plans, PBMs were originally positioned as tools to reduce drug costs and manage utilization. But over the past two decades, PBMs have transformed into powerful financial intermediaries that control pricing, formulary access, and revenue flows—often in ways that directly conflict with the interests of the employers funding the benefit. Today, many PBMs operate as opaque profit centers, designing formularies that maximize retained rebates and fees rather than net cost savings. For self-funded employers, this means that the true price of a drug, the basis for member cost-sharing, and the rebates generated by their plan's utilization are often undisclosed, unverifiable, and misaligned with value. Employers are left managing one of their

largest budget items without access to the pricing, contract, or claims data necessary to evaluate performance or exercise fiduciary oversight.

PBMs sit at the center of a system in which manufacturer rebates—intended to lower net drug costs—are often used instead to generate profits. While many large employers and coalitions have purportedly moved to 100% rebate pass-through contracts, this does not guarantee that employers receive the full value of manufacturer discounts. In practice, "pass-through" is defined variably and may exclude data fees, price protection rebates, administrative allowances, and off-invoice discounts. A 2023 Drug Channels found that only about 60% of employers report receiving full rebate pass-through, even under contracts labeled "pass-through," suggesting many remain unaware of retained revenue through affiliated entities or internal fee channels.[xxiv]

This system distorts clinical and economic value. PBMs financially benefit when higher-cost drugs secure favorable formulary placement due to larger rebate payments. These rebates are rarely shared directly with the patient at the point of sale, meaning that patients pay more out of pocket for drugs that are on the formulary precisely because of their high list price. In one example cited by the FTC, a lower-cost, therapeutically equivalent drug was excluded from the formulary in favor of a brand drug with a substantially higher list price and associated rebate.[xxv] This "rebate trap" encourages manufacturers to raise list prices to maintain market share—a cycle in which PBMs profit, and both patients and payers lose.

Pass-Through Rebate Models That Fail to Deliver

Employers are often told they are receiving "100% pass-through" of manufacturer rebates. But studies and market reviews consistently show that even when this language is included in contracts, true transparency is lacking. Surveys from employer purchaser coalitions have largely found that large self-funded employers frequently do not receive itemized rebate statements, are denied insight into how rebate amounts are calculated, and are excluded from contracts with the offshore rebate aggregators that actually receive the funds. Such entities include Ascent Health Services, affiliated with Cigna and Express Scripts and domiciled in Switzerland; Zinc Health Services, affiliated with CVS Caremark and domiciled in Delaware; and Emisar Pharma Services, affiliated with UnitedHealth Group and OptumRx and domiciled in Ireland. These aggregators serve as

intermediary entities that collect and hold rebates on behalf of the parent PBMs. These entities are domiciled offshore precisely because they are shielded from fiduciary oversight and audit. As a result, even in contracts marketed as "100% pass-through," plan sponsors are left unable to verify the full rebate value collected, what portion was retained by the aggregator or its affiliates, or what administrative or service fees were deducted prior to remittance.

For example, a self-funded employer contracting with Express Scripts may be told that all rebates are "passed through" under a transparent, pass-through model. However, the actual rebate is first collected by Ascent Health Services, a Cigna-owned entity based in Switzerland. Because the funds are routed through this offshore aggregator, the employer has no legal right to audit Ascent's books — and thus no ability to verify whether the rebate started at $500 per claim but was reduced to $300 after internal deductions. The employer sees only what is remitted, not what was negotiated, collected, or retained — creating a substantial blind spot in fiduciary oversight and total cost analysis.

Consider the below examples taken from a recent complaint filed by current and former employees of Johnson & Johnson, for breach of fiduciary duty related to their pharmacy benefit and PBM oversight.

[Intentionally Blank]

Generic Drug Name	Quantity	Pharmacy Acquisition Cost	Price J&J Agreed To Pay	Markup %
abacavir	180	$111.60	$322.36	**188.85%**
abacavir-lamivudine	90	$180.90	$1,629.40	**800.72%**
abiraterone acetate	90	$82.80	$5,375.26	**6,391.86%**
atazanavir sulfate	90	$313.20	$613.10	**95.56%**
azathioprine	90	$16.20	$27.42	**69.26%**
capecitabine	90	$47.70	$2,099.91	**4,302.33%**
cyclosporine	90	$774.90	$732.39	**-5.49%**
dalfampridine	90	$45.90	$2,197.71	**4,688.04%**
deferasirox	90	$177.30	$8,199.75	**4,524.79%**
dimethyl fumarate DR capsule	180	$120.60	$16,070.94	**13,225.82%**
droxidopa	90	$230.40	$5,340.66	**2,217.99%**
efavirenz	90	$277.20	$2,016.99	**627.63%**
mtricitabine-isoproxil fumurate	90	$115.20	$7,097.43	**6,060.96%**
he-tenofovir	90	$49.50	$1,260.12	**2,445.70%**
sodium	1	$13.72	$18.71	**36.37%**
	180	$2,889.00	$2,172.29	**-24.81%**
	90	$545.40	$1,351.43	**147.79%**
	90	$876.60	$13,325.83	**1395.60%**
ux sodium	72	$3,854.88	$8,796.92	**128.20%**
glatiramir	36	$4,738.68	$13,778.52	**190.77%**
ibandronate	3	$11.34	$32.56	**187.13%**
imatinib mesylate	90	$160.20	$16,398.17	**10,136.06%**
lamivudine	90	$76.50	$114.80	**50.07%**
lamivudine-zidovudine	90	$72.00	$223.52	**210.44%**
mycophenolate mofetil tablet	90	$25.20	$18.00	**-28.57%**
mycophenolate sodium tablet	90	$16.20	$145.06	**795.43%**
nevirapine	90	$12.60	$8.50	**-32.54%**
nevirapine XR tablet	90	$386.10	$530.63	**37.44%**
octreotide acetate	15	$138	$178.21	**29.14%**
ribavirin tablet	90	$61.20	$78.57	**28.38%**
ritonavir tablet	90	$89.10	$465.62	**422.59%**
sildenafil citrate	18	$3.78	$20.96	**454.50%**
sirolimus	90	$209.70	$704.56	**235.98%**
sofosbuvir/velpatasvir	28	$7,793.52	$8,160.00	**4.70%**
tacrolimus	90	$13.50	$17.77	**31.63%**
tadalafil tablet	18	$2.88	$64.11	**2,126.04%**
temozolomide	90	$1,242.00	$15,332.32	**1,134.49%**

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Excerpt from Lewandowski vs. Johnson & Johnson, *Lewandowski v. Johnson & Johnson, Filed 2/5/2024, District of NJ, Camden Vicinage*

Multiple high-profile ERISA lawsuits have now been filed by employees of major corporations alleging that their employers—by failing to adequately oversee PBM arrangements—breached their fiduciary duties. In one such case against Wells Fargo, plan participants alleged that the employer reimbursed its PBM for generic drugs at rates several times higher than market benchmarks.[xxvi] The complaint cited examples of 90-day fills for generic medications reimbursed at over 600% above cash pricing. A similar lawsuit against JPMorgan Chase made nearly identical claims, with specific allegations that the PBM arrangement resulted in systemic overpayments and excessive spreads, with no justification disclosed to the plan sponsor or its fiduciaries.[xxvii]

These are not isolated events—they are symptomatic of a model that obscures actual acquisition cost and prevents employers from fulfilling even the most basic of fiduciary functions: ensuring that plan assets are used prudently.

Formulary Manipulation and Higher Costs at the Counter

This rebate-centric model also distorts formulary design. PBMs have a financial incentive to prioritize drugs that offer the highest rebates, even when lower-cost, clinically comparable alternatives exist. In practice, this often leads to:

- Exclusion of lower-cost generic or biosimilar options;
- Placement of high-rebate drugs in preferred formulary tiers;
- Increased patient out-of-pocket costs due to coinsurance applied to inflated list prices.

A 2022 analysis by the Drug Channels Institute found that in some cases, the rebate on a brand-name drug exceeded 60% of its list price—creating a direct financial incentive for PBMs to favor high-list-price products.[xxviii] These higher list prices increase patient cost-sharing, particularly for those with coinsurance-based designs or high-deductible plans.

Rebate Clauses That Block Genetic Testing

Across all major PBMs, self-funded employers are increasingly encountering contract provisions that explicitly restrict or discourage the use of genetic or pharmacogenomic (PGx) testing. These types of tests—while not universally appropriate—can be critical tools for both improving health outcomes and reducing wasteful spending. Genetic and PGx tests can help identify which treatments are most likely to be effective based on a patient's unique genetic makeup, potentially avoiding trial-and-error prescribing, adverse drug reactions, and unnecessary procedures. In oncology, for example, genomic testing can guide precision therapies that extend life and reduce ineffective treatment cycles. In behavioral health, PGx testing may help tailor psychiatric medications that often require lengthy dosage adjustments. For employers, the value proposition is clear: more personalized, effective care that avoids downstream complications and unnecessary costs. Blanket restrictions or silent exclusions that limit access to these tests—without regard to medical necessity—can lead to suboptimal care, higher costs, and increased liability.

However, employers are being told by their PBMs that such testing could "interfere with or diminish rebate guarantees," and warn that employers may forfeit manufacturer rebates if PGx testing is used to guide formulary decisions or clinical protocols. Typically, the language specifies

that if a plan sponsor mandates or promotes genetic testing to assess patient response or drug efficacy—particularly for drug classes with large rebate flows—the PBM reserves the right to reduce or withhold rebate payments tied to those categories. This contractual design has a chilling effect on clinical innovation and undermines the ability of employers to optimize therapies based on individualized patient needs.

Rather than support tools that enhance safety and reduce waste, these provisions prioritize rebate preservation over evidence-based medicine—a dynamic that is fundamentally misaligned with the fiduciary and clinical interests of plan sponsors and patients alike. This structure puts employers in a perverse position: improving the clinical precision of prescribing—through widely validated genetic screening tools—could void their rebate guarantees and expose them to millions in lost funding. This is more than a financial distortion. It is a clinical safety concern. For example, we now know that 10–20% of patients carry genetic variants that impair opioid metabolism, reducing the efficacy of common medications or increasing the risk of adverse outcomes. If my child were diagnosed with a serious condition—painful or life-threatening—and a simple genetic test could determine which treatment would be most effective, most quickly, the notion that such testing would be blocked because it disrupts a PBM's rebate contract is deeply disturbing.

These arrangements suggest that PBMs are not merely administrators—they are gatekeepers of clinical care, with a financial interest in avoiding diagnostic tools that might reduce utilization of higher-rebate drugs. This represents a direct conflict with the clinical and fiduciary goals of employer-sponsored plans.

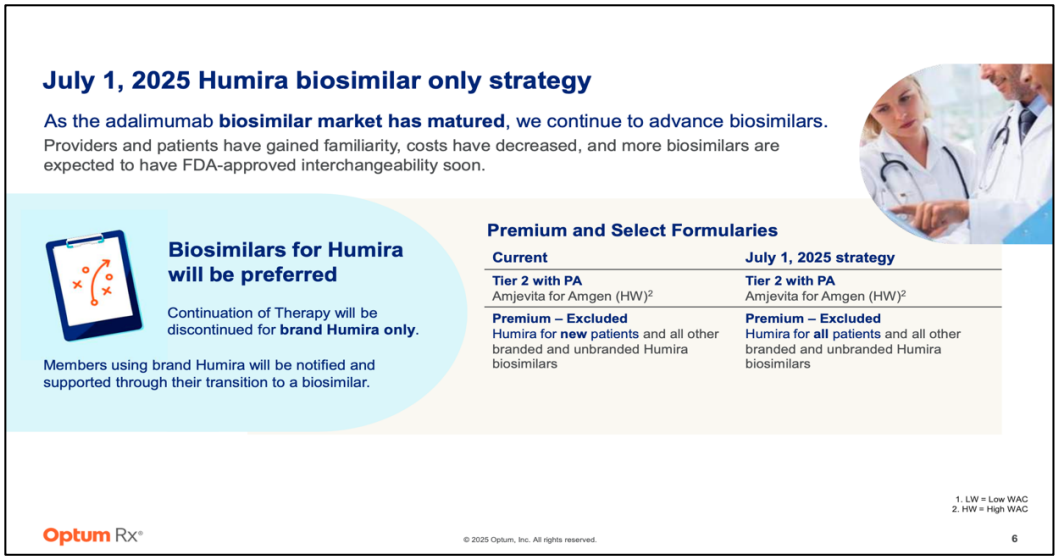
PBM Vertical Integration Across Manufacturing and Distribution:

Another growing concern for employers is the extent to which pharmacy benefit managers (PBMs) have vertically integrated across the pharmaceutical supply chain—embedding themselves not just in dispensing and claims processing, but also in drug sourcing and distribution. Increasingly, PBMs have launched private-label subsidiaries that act as exclusive distributors for select medications. These subsidiaries are typically branded as separate entities but are wholly owned and operated by the PBM's parent company. By entering into exclusive distribution agreements with drug manufacturers, PBMs are able to bypass traditional wholesale channels and route

dispensing through their own internal infrastructure—generating additional revenue streams that are often opaque to plan sponsors.

This structure gives the PBM control over the entire transaction: it can decide which drug is covered on the formulary, require that the drug be dispensed through its own distribution arm, and then retain undisclosed margins on both the administrative and distribution sides. In effect, the PBM is no longer negotiating on behalf of the employer—it is negotiating with itself.

For example, in 2025, OptumRx notified many self-funded employer clients that Humira would be removed from their formularies and replaced with Amjevita, a biosimilar manufactured by Amgen. However, Amjevita is not available through traditional wholesalers or retail pharmacy channels. It is sold exclusively through Nuvaila—a private-label distributor wholly owned by Optum. That means Optum not only selected Amjevita as the preferred biosimilar on formulary but also positioned itself as the sole source of access to the drug. By owning the distribution channel outright, Optum is able to capture spread pricing, collect distribution fees, and potentially retain profits that would otherwise go to an independent vendor—all while presenting itself to employers as a neutral fiduciary.



Example of Optum Rx Humira Biosimilar Strategy for self-funded plan

These deals often include dual pricing — a high list price version to preserve rebate-based economics for some clients, and a low list price version for others. But whether employers are in

a rebate model or not, the PBM captures revenue either way, now as both middleman and market maker. This type of vertical integration may generate short-term savings on specific drugs, but it undermines market competition, restricts access for competing biosimilars, and prevents employers from evaluating the true net cost of care. Worse, it creates conflicts of interest that are not currently disclosed in any meaningful way — not in 408(b)(2) disclosures, not in gag clause attestations, and not in plan audits. Employers are left blind to the margin capture and strategic incentives driving these formulary decisions.

What began as formulary management has now evolved into full-scale channel ownership. The PBM business model has evolved into a complex, self-reinforcing system of rebate capture, formulary distortion, opaque pricing, and contractual interference in care design. Employers cannot audit what they cannot see. Patients cannot trust what they do not understand. Policymakers cannot regulate what is shielded by legal firewall and confidential arrangement. Unless we address the structural opacity in PBM operations—starting with full disclosure of all revenue streams, affiliate contracts, rebate terms, and formulary governance—efforts to reduce drug costs and improve patient outcomes will continue to be undermined.

V. The 340B Program: A Case Study in Mission Drift, Market Distortion, and Lack of Transparency

The 340B Drug Pricing Program was established in 1992 with a narrow mandate: allow safety-net providers to purchase outpatient drugs at significantly discounted prices to enhance access for low-income and uninsured patients.[xxix] Had the program remained focused on this mission—delivering lower-cost medications within the confines of eligible safety-net settings—its impact on commercial purchasers would likely have remained minimal.[xxx] Instead, the program has grown dramatically in scope, scale, and strategic use. According to MedPAC and HRSA data, 340B purchases exceeded $54 billion in 2022, up from just $10 billion in 2013, a more than fivefold increase in less than a decade.[xxxi] This growth has occurred without proportional oversight, accountability, or payer visibility—and it increasingly affects commercially insured populations, including self-funded employer health plans.

Today, over 55,000 contract pharmacy arrangements exist, up from fewer than 1,500 in 2010.[xxxii] Many of these arrangements allow covered entities to purchase drugs at steep 340B discounts—typically 25% to 50% off list price—and then bill employer-sponsored plans at full commercial reimbursement levels. The provider retains the spread, while the employer, and often the patient in the form of cost-share, bears the full cost. There is no claim-level flag to identify whether a prescription or infusion was filled under 340B pricing, and no contractual obligation for providers or PBMs to disclose this information to employer plans. As a result, 340B has become a material cost driver for the commercial market, and a source of profit extraction that is completely opaque to the very payers funding the claim. Several consequences follow.

Employers Pay Commercial Rates for Discounted Drugs

Employer-sponsored plans are routinely billed full commercial reimbursement for medications that were purchased under the 340B discount schedule. A 2025 analysis by the National Pharmaceutical Council found that commercial prices at large 340B hospitals were approximately 7% higher—outpatient service prices nearly 20% higher—resulting in an estimated $36 billion in extra annual spending for employers. Growth in 340B activity accounted for roughly 8% of employer-based premium increases, translating into $23 billion in additional employer costs in 2023.[xxxiii] Moreover, because 340B discounts are not disclosed at the claim level, plan sponsors cannot determine whether they are overpaying—or if patients are incurring coinsurance on a price that is far above actual acquisition cost. This creates a dual financial harm: higher plan spend and inflated out-of-pocket costs.

Site-of-Care Steering to Maximize 340B Spread

One of the most significant and well-documented commercial consequences of the 340B program is site-of-care shifting—that is, moving drug administration from lower-cost outpatient physician offices to hospital outpatient departments (HOPDs). Why? Because hospitals that qualify for 340B can generate substantially greater margins on drugs administered in their outpatient settings, even when no clinical benefit exists to justify the site shift.

This practice has direct and growing financial consequences for employer-sponsored health plans. When a drug like Remicade or Keytruda is administered in a physician's office, the total cost to

the plan might be $4,000–$6,000 per infusion. When administered at a 340B-participating hospital outpatient department, the same drug can cost two to three times more—often exceeding $12,000 per dose. These inflated rates are then billed to employers and insurers at full commercial price, even though the hospital may have purchased the drug at a deep 340B discount (sometimes as low as 50% off or more). Employers and their third-party administrators are rarely aware that the drug was 340B eligible, let alone where and how it was acquired or administered. There is no requirement to identify 340B claims on the bill, and because most employers lack claims-level transparency, they cannot steer volume to lower-cost sites or evaluate whether the care setting was clinically appropriate.

The financial impact is enormous at scale. Hospital-administered 340B drugs now account for billions in excess spending annually. The National Alliance of Healthcare Purchasers estimated in 2024 that 340B-related site-of-care shifting drives approximately $36 billion in excess commercial spending each year.[xxxiv] These shifts do not correlate with improved outcomes or patient safety and often reflect profit-maximizing behavior rather than clinical need. According to researchers at the National Bureau of Economic Research (NBER), hospitals acquired physician practices and shifted drug delivery to outpatient departments specifically to benefit from 340B margins—with no associated increase in care quality or access.[xxxv] These site-of-care shifts result in higher costs for employers without corresponding improvements in quality. In the absence of transparent data and claim-level identifiers, plan sponsors are left paying more for the same care—without the tools to manage or mitigate the impact.

Payers Lack Visibility—and Are Excluded from Their Own Discount Opportunities

Despite the growing impact of the 340B program on commercial healthcare spending, there is still no reliable way for employer-sponsored plans to identify which claims were filled using 340B-discounted drugs. This is because 340B eligibility is tracked internally by hospitals and contract pharmacies—often after the claim is paid—using systems that are not connected to commercial claims processing or disclosed to payers. There are no mandatory claim-level indicators, no pricing flags, and no contractual obligation to notify employer plans when a 340B drug is dispensed—leaving payers entirely blind to the financial and clinical implications. Employers and other

commercial purchasers are left unable to discern whether they are funding 340B margins, missing out on rebate opportunities, or overpaying relative to non-340B alternatives.

Moreover, 340B claims are ineligible for manufacturer rebates, meaning the employer plan may be deprived of both the direct price discount and any potential downstream rebate value—without even knowing it. While the rebate model is deeply flawed and often fails to deliver genuine affordability, to the extent it *does* reduce net costs for employers and their members, they should retain the ability to access and benefit from those savings. The result is what many describe as a "double disadvantage": paying more, while receiving less.

An example of the negative impact, or lost opportunity, can be shown with the drug Humira, used to treat conditions such as rheumatoid arthritis and Crohn's disease. It is among the highest-expenditure drugs for employer-sponsored health plans. In the commercial market, employers typically pay $6,000 or more per injection—administered biweekly—for each covered patient. However, when Humira is delivered through a hospital outpatient department, particularly one participating in the 340B Drug Pricing Program, the financial structure changes substantially—though the employer and patient are rarely informed.

340B hospitals can purchase Humira at deeply discounted rates—often 50% to 60% off list price, and in some cases, due to Medicaid "best price" rules, for as little as $0.01 per dose. Yet, these same hospitals may bill employer health plans at the full commercial reimbursement rate, which can exceed $9,000 per injection in New Jersey. For a patient receiving 26 injections per year, this creates the following hypothetical cost structure as follows:

- Hospital acquisition cost (340B): ~$2,500 per dose → $65,000 annually
- Employer billed charge (commercial rate): ~$9,000 per dose → $234,000 annually
- Difference retained by the provider: $169,000 per patient, per year

In contrast, if the same drug had been dispensed through a pharmacy benefit, the employer would typically be eligible for manufacturer rebates totaling $4,000 to $4,200 per dose. When properly structured and passed through, this would reduce the plan's net annual cost to approximately $52,000 per patient.

The delta between the two pathways is substantial:

Hospital-based administration (340B): $234,000
Pharmacy benefit with rebate: $52,000
→ Excess employer cost: ~$182,000 per patient, per year

At scale, for a plan with 750 members on Humira:

$182,000 × 750 = **$136.5** million in avoidable spending annually.[xxxvi]

This level of avoidable spending underscores the need to examine how vertically integrated entities—across hospitals, PBMs, and affiliated pharmacies—shape drug channel decisions and influence total cost of care.

Vertically Integrated PBMs Profit from 340B—Without Disclosure

Major PBMs have entrenched themselves in the 340B drug pricing program, extracting significant revenue through vertically integrated subsidiaries while shielding those activities from employer-sponsored plans. CVS Health, for example, owns Wellpartner, a leading 340B third-party administrator (TPA), and operates one of the largest 340B contract pharmacy networks through CVS and CVS Specialty. As of 2022, CVS accounted for over 25,000 unique 340B contract pharmacy relationships—more than any other entity.[xxxvii] UnitedHealth Group's OptumRx controls Avella and Diplomat, now operating under Optum Specialty Pharmacy, which participates in 340B dispensing and administrative services.[xxxviii] Express Scripts (owned by Cigna) similarly owns Accredo, a specialty pharmacy and 340B contract participant. These three PBMs—CVS Health, OptumRx, and Express Scripts—collectively operate the vast majority of 340B contract pharmacies and are estimated to capture approximately 60% of 340B contract pharmacy revenue, according to a 2021 Berkeley Research Group analysis.[xxxix]

Additionally, about 69% of total contract pharmacies are PBM-affiliated—53% vertically integrated and 16% affiliated.[xl] These figures underscore the extent to which vertically integrated PBMs extract revenue from the original intent of the 340B discount program, while employer health plans remain largely unable to identify, audit, or recoup these margins. This structure creates a dual incentive: PBMs profit from routing claims through their own contract pharmacy entities while simultaneously denying full pass-through savings to employer health plans. Despite acting

as trusted administrators for plan sponsors, PBMs are under no legal obligation to disclose their revenue from 340B participation. The result is a closed loop in which PBMs steer high-cost specialty drugs toward 340B channels that inflate gross costs and enable margin retention for both the PBM and hospital—while the employer remains blind to the transaction and the patient may pay inflated coinsurance based on full list prices.

A Note on the Counter Argument:

Nearly every stakeholder that supports the 340B program—whether hospital systems, contract pharmacies, or third-party administrators—invokes the Congressional intent of the legislation which was designed to "stretch scarce federal resources". It is a powerful phrase, and one that appears in the 1992 House Conference Report accompanying the Veterans Health Care Act, creating the 340B program (P.L. 102–585).[xli] But citing that language without acknowledging the program's transformation—and its growing financial impact on both public and private payers—offers an incomplete and misleading picture. What once may have stretched federal resources has now become a key driver of their depletion. Commercial purchasers, in particular, are absorbing higher costs through opaque pricing arrangements and site-of-care shifts designed to maximize 340B revenue capture. If we are to take the program's original intent seriously, then reform must include a hard look at the mechanisms that now undermine affordability and equity for the very stakeholders the system was meant to serve.

VI. Conclusion: Transparency is the Trigger—And the Path Forward Is Clear

Transparency is not a silver bullet. But it is the essential trigger—the condition precedent—for accountability, informed purchasing, fiduciary compliance, and cost control. Without it, we are left managing a system we cannot see, evaluating contracts we cannot access, and paying bills we cannot audit.

This is not a market failure. It is a policy failure—decades in the making. And it will take policy to correct it. We are no longer in the dark about what's broken. Today's system of structurally misaligned incentives, vertically integrated monopolies, and impenetrable financial flows is not the result of natural market dynamics—it's the product of choices. Congress has made efforts to improve transparency and oversight in health care, but significant policy gaps continue to

undermine accountability. It has allowed safe harbors for group purchasing organizations and rebate aggregators, enabled vertical integration among payers, PBMs, and providers without requiring disclosure of ownership or financial interests, and failed to enforce even the most basic transparency measures around pricing, payments, and administrative costs. These choices—whether by design or by omission—have allowed opacity to persist in a system consuming nearly one in every five dollars of our economy. Stronger, enforceable guardrails are urgently needed to align incentives, protect plan assets, and restore trust in the system.

Policy choices led us here. Better policy can lead us out.

We now have clear legislative options that can move us forward:

- **PBM reform** must ensure that plan sponsors have access to the information and contractual rights necessary to fulfill their fiduciary obligations. This means full transparency into all forms of compensation—including rebates, fees, and retained margins—regardless of how they are labeled or routed. It also requires protections against spread pricing, self-dealing, and contractual barriers that prevent employers from accessing lower-cost drugs. While rebates can theoretically serve as a cost-containment tool, in practice they often distort incentives and drive formulary design in ways that prioritize volume and rebate yield over clinical value and affordability. At a minimum, employers must be empowered to evaluate these trade-offs, demand pass-through, and explore alternative models that better align pharmacy benefit design with patient outcomes and plan savings.
- **Strengthen hospital price transparency enforcement.** The Patients Deserve Price Tags Act, introduced by Senators Marshall and Hickenlooper, builds on the existing Hospital Price Transparency Rule by codifying requirements for hospitals to publicly disclose machine-readable files of negotiated rates, standardizing reporting formats, and establishing robust enforcement measures. It increases civil monetary penalties for noncompliance, requires HHS to maintain a public list of violating hospitals, and directs CMS to audit a statistically significant sample of hospitals each year. Together, these provisions aim to transform hospital pricing data from a compliance formality into an actionable resource that patients, employers, and purchasers can use to compare prices and steer care.

- **Ensure Employers Have Real-Time Access to Claims-Level Payment Data**. The Patients Deserve Price Tags Act mandates real-time, claims-level transparency. Not generalized tools or averages—but actionable, plan-specific pricing at the point of decision. It also addresses employer access to claims and pricing data under ERISA, recognizing that plan sponsors cannot fulfill their fiduciary duties without full visibility into payments, contract terms, and network performance.
- **340B reform**. Must bring transparency and accountability to a program whose original safety-net mission has been co-opted for commercial arbitrage. Employer-sponsored health plans are being charged full commercial reimbursement for drugs acquired at steep 340B discounts, with no disclosure, audit rights, or ability to recoup savings or rebates lost. These are not theoretical dollars—they are real costs paid by school districts, state and local governments, union benefit funds, and private-sector employers who are simply trying to provide health coverage.

  To be clear, I recognize there are multiple constituencies with legitimate concerns about the 340B program—from safety-net hospitals navigating underfunded care, to pharmaceutical manufacturers raising concerns about duplicate discounts, to policymakers worried about geographic disparities and program integrity. But virtually every stakeholder group—patients, employers, state governments, even former HRSA officials—acknowledges the need for reform. The only entities not calling for change are those profiting handsomely from the program's unchecked growth. That should speak volumes.

None of these measures amount to heavy-handed regulation. They are the minimum conditions for a functioning market. The truth is, those who cry "overregulation" are often those who have benefited most from opacity.

Transparency is not anti-market. It is the market.

Markets do not work when prices are hidden, incentives are misaligned, and purchasers are blocked from seeing how and where their money is spent. Self-funded employers are not bystanders—they are the largest collective purchaser of health care in the country, covering more than 165 million Americans. They have the leverage to demand better—and when equipped with data and rights,

they can drive the market toward value, accountability, and affordability. When employers lead, their employees—the American people—move with them.

We need Congress to codify transparency, give employers the tools to meet their fiduciary duty, and dismantle the legal barriers that hide costs and block oversight.

This isn't about punishing success. It's about ensuring that those who pay—employers, employees, taxpayers—have a right to know what they're paying for.

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[i] Centers for Medicare & Medicaid Services (CMS), National Health Expenditure Data, 2023 – Government spending accounts for approximately 46% of national health expenditures.

[ii] CMS, National Health Expenditure Data, 2023 – Medicare: $1.018 trillion; Medicaid: $834 billion; Total: $1.852 trillion.

[iii] Congressional Budget Office (CBO), "The Tax Treatment of Employment-Based Health Insurance", December 2022 – Estimated $330 billion in forgone federal revenue.

[iv] Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2023 to 2033", May 2023 – ACA exchange subsidies estimated at $90 billion in 2023, projected to rise to $118 billion by 2033.

[v] Bureau of Economic Analysis (BEA) and State Health Access Data Assistance Center (SHADAC) – Public employer contributions (K–12, state/local government) total in the hundreds of billions; for example, California public employers alone spend over $15 billion annually on employee health benefits.

[vi] Even when CMS verifies the presence of machine-readable files, it does not verify whether the data inside them is accurate or complete. A 2023 report by the Government Accountability Office (GAO) found that CMS "does not have procedures to assess the accuracy of the information hospitals post," meaning hospitals could technically comply while still posting misleading or incorrect prices.

[vii] PBGH Response to RFI on Identifying Challenges and Improving Compliance and Enforcement Processes Related to the Hospital Price Transparency ("HPT") Rule; July 21, 20225

[viii] Christopher Whaley, Nandita Radhakrishnan, Michael Richards, Kosali Simon, Benjamin Chartock, Understanding health care price variation: evidence from Transparency-in-Coverage data, *Health Affairs Scholar*, Volume 3, Issue 2, February 2025, qxaf011, https://doi.org/10.1093/haschl/qxaf011 ("aggregating these universal pricing data across payers and providers has proven difficult for researchers, due to both obfuscation by payers and administrative challenges in roll-out and standardization of the data").

[ix] UnitedHealth Group, *Q1 2024 Earnings Report*, April 2024; Optum Health now employs over 90,000 physicians across direct and affiliated practices; DOJ Press Release, *UnitedHealth Group and Change Healthcare Merger Challenge*, February 2022; Change processes one in three U.S. healthcare transactions

totaling over $2 trillion annually; UnitedHealth Group, *2024 Investor Fact Book*; Optum accounts for more than 52% of company revenue as of FY2023.

[x] U.S. Senate Finance Committee Hearing Testimony, *PBM Business Models and the Rebate Aggregator Loophole*, March 2023; Ascent Health Services is registered in Switzerland and facilitates manufacturer payments

[xi] U.S. Senate Majority Staff Report, *"Profits Before Patients: How 340B Contract Pharmacies Exploit a Safety-Net Program"*, February 2025. CVS Health SEC Filings, Form 10-K for FY2023, filed February 2024; Wellpartner revenues and segment details.

[xii] KFF, *2023 Employer Health Benefits Survey*, November 2023: https://www.kff.org/report-section/ehbs-2023-summary-of-findings

[xiii] Health Affairs, "The Erosion of Employer-Sponsored Insurance," July 2023.

[xiv] KFF, *2023 Employer Health Benefits Survey*, Figures 7.1–7.4.; National Bureau of Economic Research (NBER), *Information Frictions in Health Care Markets*, 2022.

[xv] (Mitchell, Jun 2019) "Testimony for Senate HELP Committee, Lower Health Care Costs: Creating Functional Markets and Purchasing Value for Patients." PBGH

[xvi] See, PBGH (Oct. 31, 2023) "Letter to Tri-Agencies re: Attestation Requirement Related to Section 201 of the 2021 Consolidated Appropriations Act (CAA), Prohibiting Gag Clauses" and PBGH (Mar. 15, 2024) "Response to the House Committee on Education and the Workforce's ERISA RFI"

[xvii] Id.

[xix] NYT, July 28, 2025 "*U.S. Opens Antitrust Investigation Into NewYork-Presbyterian"* https://www.nytimes.com/2025/07/28/nyregion/doj-ny-presbyterian-health.html

[xx] See *also Cement Workers, et al., vs. New York Presbyterian*, Case 1:25-cv-06140 (This case alleges that New York-Presbyterian used its market power to impose anti-steering and gag clauses that blocked employers and unions from directing patients to lower-cost, higher-quality providers—resulting in inflated prices and suppressed competition. Employers can't expose or challenge this kind of anticompetitive behavior unless they have full access to their claims data and contracting terms).

[xxi] Federal Trade Commission, *Pharmacy Benefit Managers: The Current Landscape and Emerging Concerns*, Interim Staff Report, July 2023.
https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-Interim-Staff-Report-July2023.pdf

[xxii] Business Group on Health, *2024 Large Employer Health Care Strategy Survey*, September 2023.

[xxiii] American Economic Liberties Project, *Why We Should Ban PBM Rebates*, February 2024. https://www.economicliberties.us/our-work/why-we-should-ban-pbm-rebates/

[xxiv] Tuesday, August 15, 2023 "Surprising Data on Employer-PBM Rebate Pass-Through Arrangements in 2023," Drug Channels Institute

[xxv] Federal Trade Commission, *Pharmacy Benefit Managers: The Current Landscape and Emerging Concerns*, Interim Staff Report, July 2023, pp. 13–14. https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-Interim-Staff-Report-July2023.pdf

[xxvi] *Navarro v. Wells Fargo & Co.*, Filed 7/30/2024, District of Minnesota

[xxvii] *Stern v. JPMorgan Chase & Co.*., Case No. 1:25-cv-02097, U.S. District, Southern District of New York

[xxviii] Fein, Adam J. "The Gross-to-Net Bubble Reached a Record $236 Billion in 2021." *Drug Channels Institute*, March 8, 2022.

[xxix] Veterans Health Care Act of 1992, Pub. L. No. 102-585, §602; Health Resources and Services Administration (HRSA), *340B Drug Pricing Program* – HRSA.gov

[xxx] MedPAC, *Report to the Congress: Overview of the 340B Drug Pricing Program*, May 2015, pp. 3–4; GAO, *340B Drug Discount Program: Increased Oversight Needed to Ensure Nongovernmental Hospitals Meet Eligibility Requirements*, GAO-20-108, December 2019.

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[xxxii] U.S. Government Accountability Office. *Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement*. GAO-18-480. June 2018. https://www.gao.gov/products/gao-18-480

[xxxiii] NPC, *Are Commercial Insurance Premiums Associated With The 340B Drug Pricing Program?*, NPC / Health Capital Group, 2025 https://www.npcnow.org/resources/are-commercial-insurance-premiums-associated-340b-drug-pricing-program

[xxxiv] National Alliance of Healthcare Purchaser Coalitions. *New Study Reinforces Impact of 340B Drug Pricing Program on Rising Healthcare Costs for Employers*. April 2024. https://www.nationalalliancehealth.org/news/new-study-reinforces-impact-of-340b-drug-pricing-program-on-rising-healthcare-costs-for-employers-roughly-36-billion-a-year-in-extra-hospital-spending

[xxxv] Jacobson, Mireille, et al. *Does Medicare Reimbursement Drive Up Drug Spending? Evidence from the 340B Drug Discount Program*. NBER Working Paper No. 23904. https://pubmed.ncbi.nlm.nih.gov/29355925

[xxxvi] The estimated 340B acquisition cost of Humira is based on typical discounts available to covered entities, which range from 50% to 60% off the Average Wholesale Price (AWP), and in some cases—as documented under Medicaid "best price" rules—for as little as $0.01 per dose. The billed commercial rate for Humira administered in New Jersey hospital outpatient settings has been reported to exceed $9,000 per injection, with RWJBarnabas and other systems billing between $8,900 and $9,300 per dose. This results in an annual billed amount of approximately $234,000 per patient receiving biweekly injections. Manufacturer rebates on the pharmacy benefit side for Humira have ranged from $4,000 to $4,200 per dose, depending on contract terms and formulary positioning, which can reduce the net plan cost to approximately $52,000 per year when fully passed through. These figures are consistent with pricing analyses submitted to the Federal Trade Commission and with claims-level data reviewed by commercial plan sponsors in ongoing benefit litigation and plan design assessments. See: FTC Staff Report on PBMs, July 2024; Final 340B Majority Staff Report, U.S. House Oversight Committee, 2024; "The 340B Premium: New Data," 2024 White Paper

[xxxvii] U.S. Government Accountability Office (GAO), *Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement*, GAO-20-212 (January 2020); and 340B Report, *"CVS Health now has more than 25,000 340B pharmacy contracts"*, April 2023.

[xxxviii] 340B Report, *"OptumRx using pharmacy benefit manager position to maximize 340B revenue"*, March 2023

[xxxix] Berkeley Research Group, *"For-Profit Pharmacy Participation in the 340B Program"*, 2021. https://www.thinkbrg.com/insights/publications/340b-contract-pharmacies-analysis/

[xl] Avalere / health policy analysis (2024): 69% of contract pharmacies PBM-affiliated—53% directly integrated, 16% affiliated; https://advisory.avalerehealth.com/insights/pbm-mail-order-and-specialty-pharmacy-involvement-in-340b?

[xli] H.R. Conf. Rep. No. 102–384, at 12 (1992). ("In establishing the program, the Committee intends to enable these entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.")