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Prescribing Sunshine: How Competition & Transparency Lower Prescription Drug Costs
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Key Points:

- Since my testimony in May 2025, the Department of Labor and Congress have taken major steps to make PBM compensation transparent to employers and health plans.
- Congress also required PBMs to pass through all manufacturer rebates to health plans and, in Medicare Part D, limited PBMs to flat service fees not tied to drug prices or rebates. These changes help align PBMs with the health plans they serve.
- But aligning the interests of PBMs with health plans does not align them with patients. When patients pay coinsurance based on list prices, a health plan can save money by choosing a high-rebate drug that costs more overall because the patient pays more out-of-pocket at the pharmacy counter.
- Transparency will help the market work better by making employers threat of switching PBMs credible. But switching works mainly at contract renewal and for terms employers can see. Employers also need recourse for conduct during the contract, which is what fiduciary duty provides.
- Congress can finish the job by making PBMs fiduciaries and by basing patient cost sharing on the price of a drug after rebates, starting with employer plans and extending to Medicare Part D only with offsetting savings.
- Regulators should also use the new data to report on the state of PBM competition, make offers easier to compare, and determine whether vertically-integrated PBMs continue to steer patients to their own pharmacies.

Chairman Grassley, Ranking Member Durbin, and Honorable Members of the Committee, thank you for inviting me back to testify about pharmacy benefit managers (PBMs) and the cost of prescription drugs for American patients. My name is Neeraj Sood, and I am a Senior Scholar at the Leonard D. Schaeffer Institute for Public Policy & Government Service and Professor in the Sol Price School of Public Policy at the University of Southern California. The opinions I offer today are my own and do not represent the views of the University or Institute with which I am affiliated.

When I testified before this Committee in May 2025, I shared research showing that PBMs were doing part of their job—negotiating lower prices from manufacturers—but failing at another crucial aspect: ensuring these savings benefited patients.[1] For example, between 2014 and 2018, the share of insulin spending captured by PBMs more than doubled, from $5.64 to $14.36 out of every $100 spent.[2] We also found that a $1 increase in rebates was associated with a $1.17 increase in list prices, which raises out-of-pocket costs for patients whose cost sharing is based on list prices.[3]

At that hearing, Senator Kennedy asked me for two things I would do tomorrow to fix PBMs and lower prices for consumers. I said price transparency and fiduciary responsibility: transparency tells employers whether they are getting a bad deal, and fiduciary responsibility lets them do something about it. When he asked for other suggestions, I recommended basing patient cost sharing on the price of a drug after rebates, so that patients benefit from discounts negotiated on their behalf. And when he asked whom PBMs should serve if a plan's interests and its members' interests diverge, I said that ultimately, it should be the members.[4] This line of questioning is at the heart of my testimony today.

A lot has changed since then. Congress and federal agencies have made substantial progress on transparency. But, fiduciary responsibility remains to be addressed, and rebates still do not reliably reach patients at the pharmacy counter. Today, I will describe what has been accomplished, the problems that remain, and how to address them. My recommendations are straightforward: Congress should make PBMs fiduciaries for their core functions; it should require that patient cost sharing be based on the price of a drug after rebates; and regulators should use the new disclosure data to promote competition.

What Has Changed Since My Last Testimony

The Department of Labor's PBM Fee Disclosure Rule

In October 2026, the Department of Labor finalized a rule requiring PBMs to disclose to employers how they are paid.[5] The rule applies to large, self-insured employer plans—generally plans with 100 or more participants—for plan years beginning on or after July 1, 2027. For most

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[1] Sood, N. (2025). Testimony before the U.S. Senate Committee on the Judiciary, "PBM Power Play: Examining Competition Issues in the Prescription Drug Supply Chain," May 13, 2025. https://www.judiciary.senate.gov/imo/media/doc/2025-05-13_testimony_sood.pdf

[2] Van Nuys, K., Ribero, R., Ryan, M., & Sood, N. (2021). Estimation of the share of net expenditures on insulin captured by US manufacturers, wholesalers, pharmacy benefit managers, pharmacies, and health plans from 2014 to 2018. JAMA Health Forum, 2(11). https://jamanetwork.com/journals/jama-health-forum/fullarticle/2785932

[3] Sood, N., & Van Nuys, K. (2020). The Association Between Drug Rebates and List Prices. USC Schaeffer White Paper Series. https://schaeffer.usc.edu/research/the-association-between-drug-rebates-and-list-prices/

[4] U.S. Senate Committee on the Judiciary. PBM Power Play: Examining Competition Issues in the Prescription Drug Supply Chain, S. Hrg. 119-195 (May 13, 2025), hearing transcript. https://www.govinfo.gov/content/pkg/CHRG-119shrg61884/html/CHRG-119shrg61884.htm

[5] U.S. Department of Labor, Employee Benefits Security Administration. Fact Sheet: Pharmacy Benefit Manager Fee Disclosure Final Rule. https://www.dol.gov/index.php/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/pharmacy-benefit-manager-fee-disclosure-final-rule

employers, that means January 1, 2028. Before a contract is signed or renewed, the PBM must tell the employer:

- What services it will provide and what it expects to be paid directly by the plan.
- What it expects to receive from drug manufacturers (including rebates, fees and other payments) and how much of that it will pass through to the plan and how much it will keep.
- How much it earns from spread pricing, which is the difference between what the plan pays the PBM for a drug and what the PBM pays the pharmacy.
- How much it takes back from pharmacies, including "copay clawbacks"—where the patient's copay exceeds the cost of the drug and the PBM keeps the difference—and retroactive cuts to pharmacy payments.
- What payments or incentives it receives from manufacturers that affect which drugs are placed on the formulary, and how it directs patients to pharmacies it owns.

The PBM must then report what it received every six months (quarterly on request). Employers can audit their PBM once a year with an auditor of their choosing, and the PBM must provide claims data and its contracts with pharmacies, manufacturers and rebate aggregators. The rule also reaches payments received through the PBM's affiliates and subcontractors.[6]

The Consolidated Appropriations Act, 2026

In February 2026, Congress enacted the Consolidated Appropriations Act, 2026 (CAA), which contains the most significant federal PBM reforms to date.[7] For employer plans, the CAA has transparency requirements similar to the Department of Labor's rule, and it goes further by requiring rebate pass-through:

- **Reporting:** PBMs must send large self-funded employer plans detailed reports every six months (quarterly on request) on gross and net drug spending, rebates, spread pricing, PBM compensation, and the practices of PBM-owned pharmacies. Large, fully-insured plans can choose to receive these reports, and all group health plans receive a summary report.
- **Audits:** Employers may audit their PBM once a year, using an auditor that is not paid by the PBM.
- **Rebate pass-through:** PBMs must pass through 100% of the rebates, discounts and other payments (except for bona fide service fees) they receive from drug manufacturers and

[6]U.S. Department of Labor, Employee Benefits Security Administration. Fact Sheet: Pharmacy Benefit Manager Fee Disclosure Final Rule. https://www.dol.gov/index.php/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/pharmacy-benefit-manager-fee-disclosure-final-rule

[7]Mercer. Extensive PBM transparency reforms now law (summary of the Consolidated Appropriations Act, 2026). https://www.mercer.com/en-us/insights/us-health-news/extensive-pbm-transparency-reforms-now-law/

related entities to employer plans. PBMs therefore can no longer be paid by keeping a share of rebates.

These requirements apply to contracts entered into or renewed for plan years beginning on or after August 3, 2028. That means effectively January 1, 2029 for calendar-year plans.[8]

In Medicare Part D, the CAA goes further and changes how PBMs are paid. Starting in 2028, PBMs serving Part D plans may generally be paid only through flat-dollar service fees that reflect the fair market value of their services.[9] These fees cannot be based on a drug's list price, on rebates, or on whether a drug is placed on the formulary. All manufacturer rebates must be passed through to the Part D plan. The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule in October 2026 to begin implementing these provisions.

FTC Settlements and Changes in the Market

The Federal Trade Commission (FTC) announced settlements with Express Scripts in February 2026 and with Caremark in July 2026, and in June it withdrew its case against Optum Rx from administrative litigation to consider a proposed settlement.[10,11,12] Under the proposed orders, Express Scripts and Caremark must offer a standard benefit in which patients' out-of-pocket costs are based on the net price of a drug after rebates. The FTC estimates that the Express Scripts settlement could reduce patients' out-of-pocket drug costs by up to $7 billion over ten years, while the Caremark settlement could generate up to $8.5 billion in consumer savings, plus up to $4.5 billion in additional patient savings from point-of-sale rebates over the same period.

The largest PBMs have also announced changes to their business models. Evernorth, the parent company of Express Scripts, will eliminate after-the-fact rebates, building discounts into the price at the pharmacy counter, and patients will pay the lowest of their copay, coinsurance based on the net price, or the cash price.[13] The model starts with Cigna's fully insured plans in 2027

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[8] Fattahian, S., & Goodman, L. (2026). Consolidated Appropriations Act of 2026: The New Landscape of PBM Fiduciary Oversight. Morgan Lewis, February 24, 2026. https://www.morganlewis.com/pubs/2026/02/consolidated-appropriations-act-of-2026-the-new-landscape-of-pbm-fiduciary-oversight

[9] Centers for Medicare & Medicaid Services. Medicare Program; Implementation of Sections 6219, 6220, and 6224 of the Consolidated Appropriations Act, 2026 (proposed rule). Federal Register, October 20, 2026. https://www.federalregister.gov/documents/2026/10/20/2026-21420/medicare-program-implementation-of-sections-6219-6220-and-6224-of-the-consolidated-appropriations

[10] Federal Trade Commission. FTC Secures Landmark Settlement with Express Scripts to Lower Drug Costs for American Patients (February 4, 2026). https://www.ftc.gov/news-events/news/press-releases/2026/02/ftc-secures-landmark-settlement-express-scripts-lower-drug-costs-american-patients

[11] Federal Trade Commission. FTC Secures Major Settlement with Caremark, Resolving Antitrust Case Against Second Drug Middleman (July 14, 2026). https://www.ftc.gov/news-events/news/press-releases/2026/07/ftc-secures-major-settlement-caremark-resolving-antitrust-case-against-second-drug-middleman

[12] Federal Trade Commission. Caremark Rx, Zinc Health Services, et al., In the Matter of (Insulin), case page. https://www.ftc.gov/legal-library/browse/cases-proceedings/221-0114-caremark-rx-zinc-health-services-et-al-matter-insulin

[13] Evernorth. Evernorth Announces New Era of Pharmacy Benefit Services to Lower Americans' Medication Costs (October 27, 2025). https://www.evernorth.com/article/evernorth-announces-new-era-of-pharmacy-benefit-services-to-lower-americans-medication-costs

and becomes Evernorth's standard offering in 2028, but clients can choose otherwise.[14] Optum Rx is offering every client a model with monthly per-member fees that do not depend on list prices or prescription volume.[15] I return to these developments below.

Rebate Pass-Through and Delinking Help Align PBMs With Health Plans

When PBMs keep a share of rebates, or when their fees rise with a drug's list price, they make more money when list prices and rebates are high—even if this costs their clients more. Requiring PBMs to pass through all rebates, and in Part D paying them a flat fee for their services, removes much of this conflict. The PBM no longer profits directly from a bigger rebate or a higher list price.

Optum Rx's new model shows both the progress and its limits. Its fees no longer depend on list prices, and rebates flow to the client: over 95% of Optum Rx clients chose full rebate pass-through for 2026.[16,17] But nothing in the model requires that patients' cost sharing reflect those rebates. It aligns the PBM with the plan, not the plan with the patient.

This alignment is strongest in Medicare Part D. In the employer market, the CAA requires full rebate pass-through and detailed disclosure, but it does not restrict PBM fees in the same way. PBMs can still earn money through spread pricing or by steering prescriptions to pharmacies they own. The new rules make these payments visible to employers; they do not prohibit them. Even in Part D, the law allows plans to pay PBMs performance bonuses. If those bonuses reward the total rebates a PBM collects rather than lower net costs, the incentive to favor high-rebate drugs returns, and CMS should guard against this as it finalizes its rule.[18]

Aligning PBMs With Health Plans Does Not Align Them With Patients

Even if PBMs work only in the interest of the health plan, patients can still lose. Many patients pay deductibles or coinsurance based on a drug's list price—the price before rebates—while the plan receives the rebate. This gives the plan a reason to prefer drugs with higher list prices and large rebates, because the patient pays a larger share of the cost.

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[14] Fein, A. (2025). Cigna's Rebate-Free Pharmacy Model: Three Big Questions. Drug Channels, October 2025. https://www.drugchannels.net/2025/10/cignas-rebate-free-pharmacy-model-three.html

[15] Optum. Optum Rx introduces industry's first transparent pharmacy care model (May 11, 2026). https://www.optum.com/en/newsroom/pharmacy-medications/new-model-focused-providing-transparency.html

[16] Optum. Optum Rx introduces industry's first transparent pharmacy care model (May 11, 2026). https://www.optum.com/en/newsroom/pharmacy-medications/new-model-focused-providing-transparency.html

[17] UnitedHealth Group. Fourth Quarter 2025 Earnings Conference Call Remarks. https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2025/unh-q4-2025-remarks.pdf

[18] Centers for Medicare & Medicaid Services. Medicare Program; Implementation of Sections 6219, 6220, and 6224 of the Consolidated Appropriations Act, 2026 (proposed rule). Federal Register, October 20, 2026. https://www.federalregister.gov/documents/2026/10/20/2026-21420/medicare-program-implementation-of-sections-6219-6220-and-6224-of-the-consolidated-appropriations

Consider two drugs that work equally well. Drug A has a list price of $1,000 and a rebate of $650, so its net price is $350. Drug B has a list price of $400 and a rebate of $100, so its net price is $300. The patient pays 20% coinsurance based on the list price.

Table 1: Patient Coinsurance Based on List Price

Per prescription	**Drug A**	**Drug B**
List price	$1,000	$400
Rebate paid to the plan	$650	$100
Net price (total cost)	**$350**	**$300**
Patient pays (20% of list price)	$200	$80
Plan pays (net price minus patient payment)	$150	$220

Drug B is the better deal: it costs $50 less in total. But the plan pays $70 less if it covers Drug A, because the patient pays $120 more. A plan—and a PBM working faithfully for that plan—has a financial reason to favor Drug A. The plan's savings do not come from paying less for drugs. They come from shifting costs to patients.

Some may argue that the plan's savings eventually return to workers through lower premiums or higher wages. Research suggests that, over time, higher health care costs largely do come out of workers' wages.[19] But even then, two problems remain. Workers as a group pay $50 more in total. And the cost shifts from healthier workers to the patients who need the drug. That is the opposite of how insurance is supposed to work.

This is not just a hypothetical concern. A Brookings analysis of Medicare Part D explains that because patients' cost sharing is calculated using list prices, "Part D plans can be financially better off when patients use a product with a high list price with a sizable rebate, even if alternative products offer a meaningfully lower net price."[20] The same logic applies to employer plans whenever workers pay deductibles or coinsurance based on list prices. This is more important today because a much higher proportion of beneficiaries are in plan designs that use coinsurance and a high deductible rather than just a copayment.[21]

Nor can we count on the employer's own fiduciary duty to prevent this. Under the Employee Retirement Income Security Act (ERISA), decisions about plan design, including how cost sharing is calculated, are treated as business decisions that are not subject to fiduciary duty.[22] In

[19] Arnold, D., & Whaley, C. Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages. https://www.ftc.gov/system/files/documents/public_events/1567421/whaleyarnold.pdf

[20] Linke Young, C. (2025). Medicare's recent actions to promote access to lower cost drugs. Brookings Institution, March 28, 2025. https://www.brookings.edu/articles/medicares-recent-actions-to-promote-access-to-lower-cost-drugs/

[21] Trish, E., & Blaylock, B. (2025). Shifting Cost-Sharing Burden to Beneficiaries in Medicare Part D. USC Schaeffer White Paper Series. https://schaeffer.usc.edu/research/cost-sharing-burden-medicare-part-d/

[22] Mercer. ERISA fiduciary or not – where should employers start? https://www.mercer.com/en-us/insights/us-health-news/erisa-fiduciary-or-not-where-should-employers-start/

March, a federal court dismissed claims that JPMorgan Chase breached its fiduciary duties in managing its drug benefit, finding that the challenged conduct concerned plan design and corporate decisions.[23] Put simply, rebate pass-through and delinking help align PBMs with health plans. They do not align health plans with patients.

Transparency Is Not Enough If Employers Cannot Act On It

The Department of Labor rule and the CAA will tell employers a great deal about how their PBM is paid. But disclosing a conflict is not the same as fixing it. Under ERISA, the employer is the fiduciary of its health plan and must act solely in the interest of plan participants. The CAA treats PBMs as service providers, not fiduciaries.[24] The Department of Labor rule is designed to give the employer the information it needs to judge whether the PBM's compensation is reasonable.[25] It does not require the PBM to act in the plan's best interest. Once the CAA's rebate pass-through requirements take effect, PBMs can no longer retain manufacturer rebates. But they can still keep service fees from manufacturers, earn money through spread pricing, and steer prescriptions to their own pharmacies. If an employer learns that its PBM receives large fees from a manufacturer whose drug it favors on the formulary, or steers prescriptions to its own pharmacies, the PBM has met its obligation simply by disclosing it.

And the employer's options are limited. Many PBM contracts state explicitly that the PBM is not a fiduciary and shift liability for errors back to the plan. Contract remedies such as audit rights and pricing guarantees are only as strong as the contract terms, and enforcing them is costly.

Employees are in an even weaker position. Because PBMs are not fiduciaries, employees' main avenue has been to sue their employer but they have also struggled to get into court: a federal court twice dismissed a suit by Johnson & Johnson employees over the cost of their drug benefit, finding that their claimed injuries were too speculative. The decision is now being appealed.[26]

That does not mean transparency is unimportant. Transparency will make the market work better. When employers can compare offers, the threat of switching gives every PBM a reason to offer a better deal, and we are already seeing this in the rapid move to full rebate pass-through.[27] But switching is a remedy that works at contract renewal and for terms employers can see. It is a

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[23] Stern v. JPMorgan Chase & Co. (S.D.N.Y. March 9, 2026), opinion and order. https://www.millerchevalier.com/sites/default/files/resources/General_Alerts/2026-03-09_Stern-v-JPMorgan.pdf

[24] Fattahian, S., & Goodman, L. (2026). Consolidated Appropriations Act of 2026: The New Landscape of PBM Fiduciary Oversight. Morgan Lewis, February 24, 2026. https://www.morganlewis.com/pubs/2026/02/consolidated-appropriations-act-of-2026-the-new-landscape-of-pbm-fiduciary-oversight

[25] U.S. Department of Labor, Employee Benefits Security Administration. Fact Sheet: Pharmacy Benefit Manager Fee Disclosure Final Rule. https://www.dol.gov/index.php/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/pharmacy-benefit-manager-fee-disclosure-final-rule

[26] Miller & Chevalier. The ERISA Edit: Health Plan Excessive Fee Suit Dismissed on Standing Grounds (Lewandowski v. Johnson & Johnson). https://www.millerchevalier.com/publication/erisa-edit-health-plan-excessive-fee-suit-dismissed-standing-grounds

[27] UnitedHealth Group. Fourth Quarter 2025 Earnings Conference Call Remarks. https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2025/unh-q4-2025-remarks.pdf

blunt tool for conduct that happens during a contract and is hard to detect, such as how a formulary is managed or where prescriptions are steered. It is also harder in a market where three PBMs account for nearly three-quarters of commercial prescriptions filled at retail pharmacies, and for smaller employers that lack the staff to evaluate bids.[28] Transparency and competition discipline the price of the contract; fiduciary duty disciplines conduct under it.

Policy Recommendations

Congress and federal agencies have taken important steps. The following reforms would build on this progress:

1. Establish Fiduciary Responsibility for PBMs

Congress should make PBMs fiduciaries for their core functions. The bipartisan PBM Fiduciary Accountability, Integrity, and Reform (FAIR) Act, cosponsored by Chairman Grassley, would do this.[29] It would make PBMs fiduciaries under ERISA when they maintain formularies or pharmacy networks, negotiate rebates, process claims, or perform utilization review, and it would bar contract terms that relieve PBMs of liability for breaching those duties. With fiduciary responsibility, employers would not just learn about a conflict; they could hold the PBM accountable for acting on it. Employees, and the Department of Labor, could act when employers do not. Fiduciary duty would not reach plan-design choices such as how cost sharing is calculated, which is why my second recommendation addresses cost sharing directly. Transparency allows plans and their members to see whether they are receiving good value. Fiduciary duty gives them recourse when they are not.

The PBM industry has raised several objections, summarized below. I find none persuasive.[30]

- **PBMs do not exercise discretion, so they are not fiduciaries.** In its lawsuit challenging California's PBM fiduciary law, the industry's trade association argues that PBMs "do not exercise discretionary or other fiduciary powers" and that "in almost every case, the work that PBMs perform is non-discretionary."[31] Yet the same association says PBMs save money by "negotiating directly with drug companies," "promoting competition," and "managing prescription drug benefits efficiently."[32] Its own complaint acknowledges that PBMs advise plans on what drugs to cover, how much to pay for them, and where

[28] Qato, D. M., Chen, Y., & Van Nuys, K. (2024). Pharmacy benefit manager market concentration for prescriptions filled at US retail pharmacies. JAMA, 332(15), 1298–1299. https://pmc.ncbi.nlm.nih.gov/articles/PMC11388050/

[29] PBM Fiduciary Accountability, Integrity, and Reform (FAIR) Act, S. 3549, 119th Congress (sponsor Sen. Marshall; cosponsors Sens. Kaine, Grassley and Hassan). https://www.govinfo.gov/app/details/BILLS-119s3549is

[30] Sood, N. (2026). Washington Is on the Verge of True PBM Reform. STAT, March 30, 2026; reprinted by USC Schaeffer Institute. https://schaeffer.usc.edu/research/pbm-reform-fair-act-fiduciary/

[31] Complaint, Pharmaceutical Care Management Association v. Bonta, No. 2:26-cv-00012 (C.D. Cal. filed Jan. 2, 2026), ¶¶ 4, 39. https://www.millerchevalier.com/sites/default/files/resources/General_Alerts/2026-01-02_PCMA-v-Bonta.pdf

[32] Pharmaceutical Care Management Association. PBMs Continue To Deliver Savings On Prescription Drugs For Patients (March 6, 2025). https://www.pcmanet.org/pcma-blog/pbms-continue-to-deliver-savings-on-prescription-drugs-for-patients/03/06/2025/

patients can fill prescriptions.[33] These are discretionary decisions. PBMs cannot have it both ways.

- **States cannot regulate PBMs because ERISA preempts state law.** In the same lawsuit, the industry argues that California's fiduciary requirement is preempted by ERISA.[34] Combined with the claim that PBMs are not fiduciaries under ERISA, this leaves a vacuum in which no one holds PBMs accountable. The answer is a clear federal standard, which only Congress can provide.
- **Fiduciary duty will upend existing contracts.** The industry warns that making PBMs fiduciaries "upends existing contracts."[35] If a business model depends on keeping the client in the dark, or on avoiding accountability when the PBM's interests diverge from its client's, then yes, fiduciary duty will upend that model. That is the point. PBMs that provide valuable services for fair fees have nothing to fear.

We have done this before. When many 401(k) participants could not see the fees embedded in their plans, Congress and regulators required retirement plan service providers to disclose their compensation, within ERISA's system of fiduciary duties. After these rules took effect, plan fees generally declined and participants moved toward better-value investments.[36] The retirement-services industry did not collapse. The same tools can work for prescription drug benefits.

2. Base Patient Cost Sharing on Post-Rebate Prices

Congress should require that deductibles and coinsurance be based on a drug's price after rebates, and that copayments not exceed that price. Better still, the discount should be applied at the pharmacy counter rather than paid to the employer later as a rebate check. Today, a large rebate check is often the most visible sign that a benefits department has negotiated a good PBM contract, even though it may reflect a formulary that favors drugs with high list prices. The higher list prices that come with it are blamed on industry trends. If rebates are fully passed through and reflected at the pharmacy counter, employers will judge PBMs on the total net cost of the drug benefit rather than the size of the check. This reform does two things.

First, patients pay less. Return to the example above, but now the patient pays 20 percent of the net price.

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[33] Complaint, Pharmaceutical Care Management Association v. Bonta, ¶ 38. https://www.millerchevalier.com/sites/default/files/resources/General_Alerts/2026-01-02_PCMA-v-Bonta.pdf

[34] Complaint, Pharmaceutical Care Management Association v. Bonta, ¶¶ 6, 8. https://www.millerchevalier.com/sites/default/files/resources/General_Alerts/2026-01-02_PCMA-v-Bonta.pdf

[35] Complaint, Pharmaceutical Care Management Association v. Bonta, ¶ 51. https://www.millerchevalier.com/sites/default/files/resources/General_Alerts/2026-01-02_PCMA-v-Bonta.pdf

[36] Sood, N. (2026). Washington Is on the Verge of True PBM Reform. STAT, March 30, 2026; reprinted by USC Schaeffer Institute. https://schaeffer.usc.edu/research/pbm-reform-fair-act-fiduciary/

Table 2: Patient Coinsurance Based on Net Price

Per prescription	Drug A	Drug B
Net price (total cost)	$350	$300
Patient pays (20% of net price)	$70	$60
Plan pays (80% of net price)	$280	$240
Patient payment under list-price coinsurance (Table 1)	$200	$80

The patient's payment for Drug A falls from $200 to $70, and for Drug B from $80 to $60.

Second, the plan and the patient now want the same thing. Both save money with Drug B: the patient saves $10 and the plan saves $40 compared with Drug A. The plan no longer gains by choosing a high-rebate drug that costs more overall. And larger rebates now lower what patients pay, rather than raise it. If Drug A's rebate rose from $650 to $750, the patient's payment would fall from $70 to $50. Under list-price coinsurance, the patient would still pay $200. Over time, this may reduce reliance on rebates and the high list prices that come with them.

Because the final rebate is not always known when a prescription is filled, PBMs would apply a reasonable estimate at the pharmacy counter and settle up with the plan later. Patients should never receive a bill after the fact because an estimate turned out to be wrong.

Voluntary offers are not enough. The proposed FTC settlements and the PBMs' new business models are major steps forward. But offering a better benefit design is not the same as patients getting it.

- **Coverage is incomplete.** The proposed FTC settlements cover only the companies that settled, and other PBMs are not covered.
- **Plans can opt out.** The Express Scripts settlement allows plan sponsors to choose other terms by written request, except for Cigna's own fully-insured plans.[37] Evernorth's new model is likewise a standard offering that clients can decline, and Optum Rx's model does not address patient cost sharing at all.[38,39] As the example above shows, a plan that pays less when patients pay based on list prices has a financial reason to keep the old design.

[37] Federal Trade Commission. In the Matter of Caremark Rx, Zinc Health Services, et al. (Insulin), Docket No. 9437, proposed decision and order as to the Express Scripts respondents. https://www.ftc.gov/system/files/ftc_gov/pdf/d09437caremarkproporder-esiresps.pdf

[38] Fein, A. (2025). Cigna's Rebate-Free Pharmacy Model: Three Big Questions. Drug Channels, October 2025. https://www.drugchannels.net/2025/10/cignas-rebate-free-pharmacy-model-three.html

[39] Optum. Optum Rx introduces industry's first transparent pharmacy care model (May 11, 2026). https://www.optum.com/en/newsroom/pharmacy-medications/new-model-focused-providing-transparency.html

- **PBMs may discourage adoption.** A PBM that earns less under a net-price design may try to make it less attractive, for example by charging higher fees elsewhere in the contract. The Express Scripts settlement bars charges for administering its point-of-sale rebate program, other than the actual cost of prefunding rebates, and prohibits pressuring clients toward alternatives.[40] Regulators should enforce these protections and monitor overall contract pricing.

Congress should therefore make net-price cost sharing a requirement, not an option.

Effects on premiums and the federal budget. Basing cost sharing on post-rebate prices is not free. When patients pay less at the pharmacy, plans pay more, and some of that cost may show up as higher premiums. In our example, the plan's cost for Drug A rises from $150 to $280. But the total cost of the drug does not change; what changes is who pays it. Today, patients who need expensive, highly-rebated drugs pay more at the pharmacy so that other members can pay slightly lower premiums. Spreading these costs across all members through premiums is fairer, and because plans would no longer gain by favoring high-rebate drugs, the reform can help lower total drug spending over time.

Medicare Part D requires special care, because higher plan costs translate into higher federal spending. When the Department of Health and Human Services proposed a rule in 2019 to move rebates to the pharmacy counter in Medicare and Medicaid, the Congressional Budget Office estimated that it would increase federal spending by about $177 billion over 2020–2029 (about $170 billion of it in Medicare).[41] With the implementation of the IRA, rebates for negotiated drugs and insulin have reduced, and in addition, patients have an out-of-pocket cap of $2000. These changes imply that prior estimates need to be updated, but the fiscal concern is real. Congress has two practical options:

- Apply the requirement to employer plans first and exclude Medicare Part D for now; or
- Include Part D, paired with savings from other provisions, based on a new estimate from the Congressional Budget Office.

3. Use the New Information to Promote Competition

The new disclosures will produce more information about the PBM market than we have ever had. It should be used not only by individual employers, but to make the market more competitive.

- **Report on the state of competition.** The FTC, working with the Department of Labor and CMS, should publish an annual report using aggregated disclosure data. It would

[40] Federal Trade Commission. In the Matter of Caremark Rx, Zinc Health Services, et al. (Insulin), Docket No. 9437, proposed decision and order as to the Express Scripts respondents. https://www.ftc.gov/system/files/ftc_gov/pdf/d09437caremarkproporder-esiresps.pdf

[41] Congressional Budget Office (2019). Incorporating the Effects of the Proposed Rule on Safe Harbors for Pharmaceutical Rebates in CBO's Budget Projections. https://www.cbo.gov/system/files/2019-05/55151-SupplementalMaterial.pdf

cover market shares, trends in net cost per member, the share of rebates passed through, spread pricing, the share of prescriptions filled at PBM-owned pharmacies and how those pharmacies are paid compared with independent pharmacies, how many plans adopt net-price cost sharing, and how often employers switch PBMs. The FTC should also complete its PBM study and publish a final report, as Chairman Grassley and Senator Cantwell requested last month.[42]

- **Make offers comparable.** Disclosure helps employers only if they can compare bids directly. Without common definitions, each PBM can present its own performance using the measures most favorable to it or terms specific to its company. The Department of Labor should require a standard format for disclosures, with a common measure of total net cost, patient access, standard fee categories, and independent drug classification so that employers can compare bids directly.

Each of the three largest PBMs is part of a corporation that also owns a large insurer and specialty, mail-order or retail pharmacies. This integration can harm competition. In research with my colleagues, we found that after a large insurer-PBM merger in Medicare Part D, premiums rose for rival plans that bought PBM services from the merged firm.[43] The FTC's interim staff reports found substantial markups on specialty generic drugs dispensed by PBM-affiliated pharmacies.[44]

On November 4, CVS Health announced that it plans to split into two companies by 2028. This is welcome, but problems still remain. Under the plan, CVS Caremark will stay in the same company as Aetna and CVS Specialty, while the retail stores and mail-order pharmacy go to a separate CVS Pharmacy company.[45] The PBM would keep its specialty pharmacy—the area in which the FTC found the largest markups. In addition, the plan is voluntary and could change.

The Patients Before Monopolies Act (S. 4509), now before this Committee, would prohibit common ownership of PBMs and pharmacies.[46] The evidence gives reason for concern, but forced divestiture would also be disruptive for patients who rely on PBM-owned specialty and mail-order pharmacies. I would begin by using the new disclosure data together with active antitrust enforcement to determine whether integrated PBMs continue to favor their own pharmacies. If the evidence shows that integrated PBMs continue to steer patients and

[42]U.S. Senate Committee on Commerce, Science, and Transportation. Cantwell, Grassley Urge FTC to Finish Investigation into Pharmacy Benefit Managers' Practices, Provide Final Recommendations to Congress (October 26, 2026). https://www.commerce.senate.gov/press/dem/release/cantwell-grassley-urge-ftc-to-finish-investigation-into-pharmacy-benefit-managers-practices-provide-final-recommendations-to-congress/

[43]Gray, C., Alpert, A., & Sood, N. (2026). Disadvantaging Rivals: Vertical Integration in the Pharmaceutical Market. American Economic Journal: Applied Economics, 18(1), 286–304. https://doi.org/10.1257/app.20240011

[44]Federal Trade Commission. FTC Releases Second Interim Staff Report on Prescription Drug Middlemen (January 2025). https://www.ftc.gov/news-events/news/press-releases/2025/01/ftc-releases-second-interim-staff-report-prescription-drug-middlemen

[45]CVS Health. CVS Health announces intent to create two distinct leaders in healthcare (November 4, 2026). https://www.cvshealth.com/news/company-news/cvs-health-announces-intent-to-create-two-distinct-leaders-in-healthcare.html

[46]Patients Before Monopolies Act, S. 4509, 119th Congress. https://www.govinfo.gov/app/details/BILLS-119s4509is

disadvantage rival pharmacies, Congress should then consider structural separation. Fiduciary responsibility complements this approach: a PBM that owes a duty to the plan cannot lawfully steer the plan's patients to its own pharmacies at the plan's expense.

Conclusion

Congress, regulators and the market have made real progress since I last appeared before this Committee. Employers will soon be able to see how their PBMs are paid, and PBMs will no longer keep the rebates they negotiate.

But transparency is only useful if employers can act on it, and rebates help patients only if they reach the pharmacy counter. Fiduciary responsibility will give employers and employees the ability to hold PBMs accountable. Basing cost sharing on post-rebate prices will ensure patients benefit from the discounts negotiated on their behalf, and will align the interests of health plans with the patients they serve. And the new data can help employers compare offers and allow enforcers to determine whether integration continues to harm competition.

Our pharmaceutical distribution system should work for patients, not against them. If we pair transparency with accountability and make sure discounts reach patients, PBMs will increasingly compete on the value they deliver to patients rather than on the size of the rebates they collect.

Thank you for the opportunity to testify today. I would be happy to answer any questions.