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ERIC E&C Testimony: Key Messages

February 11, 2026

The ERISA Industry Committee, which represents large employers providing health coverage to millions of Americans, highlights how the current prescription drug supply chain imposes unsustainable costs on employers and patients.

Vertical integration enables manufacturers, wholesalers, pharmacy benefit managers (PBMs), group purchasing organizations (GPOs), and other entities to extract profit through practices such as exclusionary rebates, steering patients to higher-cost drugs, and structuring contracts in ways that conceal true pricing. These practices contribute significantly to rising costs for employer plans and the patients who rely on them. PBMs have additionally expanded into white-label drug arrangements, enabling them to reprice already-approved medications at higher rates while obscuring actual acquisition costs.

More transparency and oversight is needed for each of these actors in the drug supply chain as well as to third-party administrators, brokers, and consultants, who influence employer decision-making but often have financial incentives tied to PBMs. Many have avoided legally required compensation disclosures and disregarded conflicts of interest that affect plan design, vendor choices, and competitive bidding processes. These dynamics may steer employers toward higher-cost arrangements that do not benefit patients or plan sponsors.

To address these problems, ERIC supports increasing transparency, reducing anti-competitive behavior, accelerating access to lower-cost options such as biosimilars, eliminating unnecessary biosimilar interchangeability requirements, enforcing fairness in provider contracting, and applying full fiduciary standards to PBMs. ERIC also encourages reforms that bring visibility into wholesaler margins, GPO fee structures, and the RFP processes used by employers.

Lowering Health Care Costs for All Americans: An Examination of the Prescription Drug Supply Chain

Testimony before the Subcommittee on Health

U.S. House of Representatives

Committee on Energy and Commerce

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Introduction and About ERIC

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

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

Our member companies offer comprehensive health benefits to employees, their families, and often retirees. On average, large employers pay around 80 percent of health care costs on behalf of their

beneficiaries. There are over 154 million people who receive coverage through employer-sponsored insurance and over 100 million of those receive coverage through ERISA self-insured plans.[1] All of this taken together means that the vast majority of Americans receive their health care coverage through employers, who shoulder exponential costs associated with the coverage they provide. And these costs are not projected to abate – premiums costs for employer-sponsored plans are now growing at a rate of six to seven percent each year.[2] For ERIC's member companies, some of whom provide coverage to over a million beneficiaries across the country, this translates into very real dollars – dollars that are not attributable to any revenue potential, but rather merely a loss on their books, which could have been otherwise realized as increases in wages and other employee benefits.

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

[1] KFF's analysis of data from the 2023 American Community Survey included in KFF's 2025 Employer Health Benefits Survey published October 22, 2025. See KFF. Health insurance coverage of the population ages 0–64 [Internet]. San Francisco (CA): KFF; [cited 2025 Sep 15]. [Time frame: 2023].
[2] Based on data comparison from Claxton, G., Rae, M., Damico, A., Winger, A., & Wager, E. (2025). Health benefits in 2025: Family premiums rise 6 percent, large employers increase coverage of GLP-1s for weight loss. *Health Affairs*, *44*(11). https://doi.org/10.1377/hlthaff.2025.01106

2026 (CAA26), as well as the administration's proposed improvements to the transparency in coverage rule and the proposed transparency requirements regarding fees and compensation received by pharmacy benefit managers (PBMs) and their affiliates, including affiliated providers of brokerage and consultant services, are all positive steps towards a more transparent and accountable supply chain and drug delivery system. The U.S. drug supply chain and delivery system is one in which a myriad of actors have their hand in the proverbial cookie jar well before the drug ever makes it to the patient. This complexity creates many misaligned financial incentives, which fundamentally frustrate our member companies' goals of providing quality, affordable employer-sponsored health benefits.

The U.S. health care system has become a complex web of intertwined entities, each with their own financial interests, that drive up costs. Some are involved in vertical integration that has created massive conglomerates steering patients towards more expensive drugs and even negotiating exclusionary rebates that block generics and biosimilars. Vertical integration reduces competition and transparency, leading to inflated drug costs, ultimately resulting in higher premiums and out-of-pocket expenses that force many Americans to ration or skip necessary medications. As prescription drug costs rise, employees are seeing an increased burden of out-of-pocket expenditures for the medications they and their families depend on.

For years, the strongest lobbies in Washington have held the advantage by sowing doubt about biosimilar safety, pushing unnecessary phase III trials, inventing a misleading "interchangeability" designation, and locking in 50 state substitution laws designed to restrict biosimilar dispensing.
To counter this false narrative, ERIC launched a groundbreaking initiative in 2020 with Johns Hopkins University to better understand the role that biosimilars could play in reducing health care costs. Companies that participated in the survey would have saved an average of $1.53 million on infliximab

(an autoimmune drug) if they used the biosimilar alternative.[3] Because these companies are self-insured, these savings would have gone back to the benefit plan and lowered premiums, or would have been used to improve or add new benefits. According to our data, we projected that, overall, all self-insured employer health benefit plans could have saved $1.4 billion on just two biologics in 2018 if proper biosimilar substitution had been used.[4] Over five years later, and with many more biosimilars in the market, ERIC is updating its study and hopes to share the data when available.

A Holistic Approach to Drug Affordability – Discovery, Development, and Delivery

Employers are facing significant premium pressures in 2026, with Mercer projecting that average total health benefit costs per employee will rise around 6.5 percent, the largest increase in over a decade.[5] Some industry surveys even suggested an 11 percent increase, underscoring the continued strain on employer-sponsored health benefits.[6] One factor in premium increases can be attributed to growth in drug spending, a large part of which is reflected by growth in specialty drug spending. We know from hearing from our members that, for some, sixty percent of drug spending is associated with specialty drugs and that spending only corresponds to five percent utilization.

We also know that, for some, their drug spending is expected to exceed their spending for medical benefits. This level of spending is not sustainable.

[3] "Biosimilar Medications – Savings Opportunities for Large Employers" - Johns Hopkins Bloomberg School of Public Health, March 2020
[4] Ibid.
[5] "Employers are bracing for the highest health benefit cost increase in 15 years, a projected 6.5% increase in 2026, according to Mercer." Mercer. September 4, 2025
[6] "UnitedHealthcare plans 11% premium increase, while employers demand more value". Allison Bell. BenefitsPRO. October 29, 2025.

This is why large employer plan sponsors are encouraging Congress to take a holistic approach to bringing down drug spending for employers and patients. This includes looking across a host of commonsense policy solutions supported by both parties in both chambers that are designed to encourage the discovery, development, and delivery of cheaper drug alternatives to patients.

Many of the current problems in the prescription drug market are a result of the failure by various parties to abide by the standards established by the 1984 *Drug Price Competition and Patent Term Restoration Act* (Public Law 98-417), usually referred to as the *Hatch Waxman Act*. The law strikes a balance wherein innovator companies are rewarded with market monopolies, for a limited duration of time, and then must face competition from generic products. Various strategies are now used to delay or escape entirely from that competition, and have resulted in unconscionable prices and costs to plan sponsors and patients. To this end, ERIC strongly supports several bills promoting patent reforms that, while not in this committee's jurisdiction, are important to mention given the foundational importance of fostering robust investment in biosimilar competition and generic drug discovery.

In addition to ensuring confidence in investment in these markets, Congress should also look at several ways to facilitate faster approval of biosimilars and address current regulatory obstacles that cause unnecessary delay. Unlike patent reforms, these regulatory improvements are squarely within this committee's jurisdiction, and we strongly support the committee taking action this year. This committee has a long history of leadership on encouraging the development of biosimilar therapies – the *Biologics Price Competition and Innovation Act* (BPCIA), included in the *Affordable Care Act* close to 16 years ago, was born from this committee.

At that time, there were still many questions about the promise of biosimilars – would they be safe and effective? Would they fulfill their promise to provide cheaper alternatives for patients? Over the past 16 years, this country has had extensive experience testing the safety and efficacy of these products. Yet,

outdated regulatory standards remain, causing an unnecessary roadblock for patient access to these cheaper drug therapies.

It is time for Congress to modernize biosimilar approvals and pass measures that eliminate interchangeability standards, provide better alignment of the U.S. Food and Drug Administration (FDA) and the U.S. Patent and Trademark Office (PTO) filings, and accelerate the clinical trial process requirements. For the purposes of today's hearing, however, we will focus on the delivery portion of the supply chain.

In a national survey conducted by Fabrizio Ward in 2025, more than three-in-four voters say it is very important for Congress to take action to reduce the price of prescription drugs.[7] This shows bipartisan voter interest in solutions that can be realized by employers and patients in the form of access to cheaper drug therapies, such as biosimilars. Last week, Congress delivered a down payment on delivery improvements -- bringing transparency and reform to the PBM industry. We applaud this accomplishment, setting the foundation for more delivery reforms to come. PBMs are, after all, important actors in the drug manufacturer to patient continuum, but they are not alone.

[7] "New poll finds Americans agree, drug prices are too high and Congress needs to act" – Fabrizio Ward, Arnold Ventures, April 22, 2025.

There are other actors involved in the prescription drug supply chain that need further oversight to make sure employers are getting the best deal on medications for their workers. This includes but is not limited to wholesalers, group purchasing organizations (GPOs), manufacturers who engage in white labeling practices, third-party administrators (TPAs), consultants, and brokers. According to a 2024 Eastern Research Group report prepared for U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, 58.9 percent of drug expenditures across all drugs were retained by manufacturers in 2022.[8] This breaks down to 25.9 percent for PBMS, 10 percent for wholesalers, and 5.2 percent for pharmacies.[9] Furthermore, the report found that by comparing each intermediary's margins to their actual net sales price, total margins for all retail drugs were 31.2 percent for PBMs that same year and 6.3 percent for wholesalers and 3.2 percent for pharmacies.[10] These "other middlemen" are involved in a complex system interacting with one another based on confidential contract terms and negotiations that are not transparent.[11] My testimony further explains how these actors do not have proper oversight, and lays out policy solutions Congress can act upon to bring further transparency and lower costs to patients.

[8] Eastern Research Group, Inc. (2024). An examination of pharmaceutical supply chain intermediary margins in the U.S. retail channel. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.
[9] Ibid.
[10] Ibid.
[11] "An examination of pharmaceutical supply chain intermediary margins in the U.S. retail channel: Report synopsis." Prepared for ASPE Office of Science and Data Policy - Eastern Research Group, Inc. September 27, 2024.

How Other Actors Contribute to High Drug Costs

Wholesalers

Wholesalers have received little oversight and deserve more attention due to their role in driving higher drug prices. Manufacturers generally depend on wholesale distributors to store medications and deliver them to pharmacies. In 2022, wholesalers handled about 95 percent of all retail prescription drug sales.[12] The wholesale distribution market is dominated by a small group of firms, with McKesson, Cencora (formerly AmerisourceBergen), and Cardinal collectively controlling roughly 95 percent of the market.[13] Eastern Research Group (ERG) conducted a study that found that wholesale margins were $23.4 billion in 2022.[14] Brand name drugs yielded higher margins for wholesalers in dollar value compared to generic drugs - $14.1 billion for brand drugs, compared with $9.3 billion for generic drugs in 2022, respectively.[15]

ERG calculated the margin dollars as the difference between the net sales price and the net acquisition costs, and does not include labor or services provided. Since 80 percent of U.S. prescriptions are generics[16], this means that wholesalers are getting almost 60 percent of their profits from 20 percent of name brand prescriptions. As an intermediary in the supply chain, wholesalers add to drug costs for patients. Wholesalers typically buy medications from manufacturers at the wholesale acquisition cost (WAC).

[12] "Prescription Sales via Traditional Healthcare Distributors Increase." Pharmaceutical Commerce. October 2023.
[13] "3 Stocks to Watch in the Drug Distribution Industry". Keonhee Kim. Morningstar, April 2024.
[14] "An Examination of Pharmaceutical Supply Chain Intermediary Margins in the U.S. Retail Channel: Report Synopsis. Prepared for ASPE Office of Science and Data Policy". Eastern Research Group, Inc. September 27, 2024.
[15] Ibid.
[16] Parasrampuria, S., & Murphy, S. (2022, September). Trends in prescription drug spending, 2016-2021. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

In return for distribution services or meeting specific performance targets, drug manufacturers pay wholesalers service fees. These fees are often calculated as a percentage of WAC and effectively reduce the wholesaler's actual purchase cost. Additional price reductions may come from manufacturer discounts for early payment or large purchase volumes, further decreasing the net price paid by wholesalers.

Pharmacies then purchase the prescription drugs from the wholesalers. Because wholesalers compete to supply pharmacies, they often share part, but not likely all, of the discounts and fees by offering reduced prices. This means pharmacies usually pay less than the WAC for brand-name drugs.

Additionally, wholesalers are also vertical integrators. *The Wall Street Journal* reported a major shift in the pharmaceutical supply chain where the "Big Three" U.S. drug wholesalers are aggressively acquiring oncology practices.[17] By acquiring physician groups, these distributors essentially "lock in" their own customers, ensuring that expensive chemotherapy and specialty drugs are purchased through their own distribution networks. It positions them to control more of the health care value chain and protect profit margins as the industry consolidates.

Group Purchasing Organizations (GPOS)

GPOs are another category of intermediaries in the drug supply chain that negotiate, collect, and disburse drug manufacturer rebates tied to preferred formulary status for their affiliated PBMs. Make no mistake – not all GPOs are alike. There are some GPOs that have served the market for many years as reliable partners to certain providers.

[17] "Why Drug Distributors Are Buying Cancer Specialists". David Wainer. The Wall Street Journal. September 27, 2024

To our knowledge, these are not the companies who are exploiting loopholes to generate ill-gotten revenue, and contributing to inflated drug costs. Today, there are GPOs, including some located outside of the U.S., that are effectively monopolizing the market.[18] These GPOs were formed in countries known for their lack of financial transparency and low tax rates, a tricky way to hide revenue enhancements and anti-competitive practices, such as steering patients in employer-sponsored health plans toward more expensive medications.[19] The Federal Trade Commission (FTC) launched an investigation and filed a complaint against three of the largest PBMs and their GPOs in 2024, resulting in at least one GPO moving from Switzerland to the United States, which will bring back to the U.S. more than $750 billion in economic activity.[20]

These PBMs with GPOs have effectively used a "labeling trick" to keep money that should go back to the employer plan. When an employer contracts with a PBM requiring rebate passthrough, the PBM simply moves this revenue to the GPO. This money is then not called a rebate, but a "GPO fee." Because the employer's contract only mentions "rebates," the PBM can pocket the "fees" legally. It's essentially a shell game that hides profits behind a different name and a separate company wall that the employer is not allowed to audit. In the end, the PBM exploits narrow contractual language to retain significant profits through the GPO that would otherwise be owed to the employer. This has occurred since these GPOs were created between 2019 and 2021, and thanks to the CAA26, we believe these GPO fees will be exposed for what they really are – rebates.

[18] "The role of Pharmacy Benefit Managers in prescription drug markets". House Committee on Oversight and Accountability". July 2024.
[19] "FTC Sues Prescription Drug Middlemen for Artificially Inflating Insulin Drug Prices". Federal Trade Commission. September 20, 2024.
[20] In the Matter of Caremark Rx, LLC, Docket No. 9437 (Federal Trade Commission)

ERIC also believes that CAA26 will capture all other fees and discounts paid to the PBM and its affiliates that must be fully passed through to the plan, eliminating the ability of PBMs to withhold anything more than bona fide service fees for their services. While the CAA is written in a way that would force more transparency from GPOs about their practices, these businesses are shapeshifters – known for shifting away from one practice once it becomes widely understood, and moving on to new tactics. Their involvement introduces an additional profit taker into the prescription drug supply chain that needs further oversight.

White Labeling

White labeling refers to the practice in which one company markets and sells a product under its brand even though it neither developed nor manufactured it. In pharmaceuticals, white labeling does not involve drug development or production by the branding entity. Instead, PBMs source already approved drugs from manufacturers and rebrand them, obscuring the true supplier from patients, providers, and payers. This strategy is used to further vertical integration within the health system while allowing PBMs to exert greater control over formularies, pricing, and distribution – without assuming the regulatory or financial risks born by actual drug manufacturers.

Several PBMs have expanded aggressively into white labeling arrangements. These entities function primarily as pricing and contracting intermediaries: they trade quasi-exclusive formulary placement for price concessions from manufacturers, then reprice the drugs at substantially higher levels. This opaque structure resembles a form of spread pricing, enabling PBMs to capture hidden margins while limiting transparency around true acquisition costs, rebate flows, and the drivers of rising patient prices.

The decision to locate these subsidiaries offshore further raises concerns that these arrangements are designed to shield pricing practices from scrutiny rather than to deliver efficiencies or savings to patients.

Third Party Administrators, Brokers, and Consultants

Third-party administrators (TPAs), brokers, and benefits consultants play influential, but often indirect roles in the prescription drug supply chain, particularly within employer-sponsored insurance. TPAs administer health plans on behalf of self-insured employers and commonly contract with PBMs to manage prescription drug benefits. Brokers and consultants advise employers on plan design and vendor selection, including PBM selection, formulary structures, and rebate arrangements. Brokers and consultants function as key intermediaries that shape purchasing decisions and contractual terms, giving them substantial influence over drug pricing and access.

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

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

We are also concerned with how these conflicts of interest may be shaping the management of the request for proposal (RFP) process for plan sponsors when they consider switching TPAs or PBMs. There is widespread belief that financial incentives for brokers and consultants are shaping the structure of these RFPs in a way that precludes opportunities for smaller PBMs and TPAs, and that prevents meaningful apples-to-apples comparisons on the costs that will be borne by plan sponsors and beneficiaries. ERIC is interested in reform proposals to enforce fairness and a common baseline for RFPs that plan sponsors could adopt.

The U.S. Department of Labor issued a proposed rule that would require providers of PBM services and affiliated providers of brokerage and consulting services to disclose compensation to ERISA self-insured group health plan fiduciaries. The proposal implements the directive under an executive order from President Trump last February.[21]

[21] Executive Order No. 14156, 90 Fed. Reg. 24561 (2025).

The proposed rule provides for disclosure of the following information:

- Rebates and other payments from drug manufacturers;
- Compensation received when the price paid by the plan for a prescription drug exceeds the amount reimbursed to the pharmacy; and
- Payments recouped from pharmacies in connection with prescription drugs dispensed to the plan.

Additionally, the proposed rule would allow plan fiduciaries to audit the accuracy of PBM disclosures and provide additional relief to plan fiduciaries if their PBM fails to meet its obligations. ERIC is grateful to the Department for its work on this proposed rule, as it incorporates many of the ERIC-led policy recommendations we have relayed to the administration and Congress, and fosters greater transparency for employers and patients.

Policy Solutions for Committee Consideration

ERIC supports a broad array of policy reforms to address the challenges outlined above. Several of these measures have already been introduced in bipartisan legislation and are ripe for consideration. These bills are intended to spur faster adoption of and access to biosimilars, enhance transparency across stakeholders, and foster fairness in provider contracting:

- Biosimilar Red Tape Elimination Act (H.R. 5526)
    - Led by committee members Congressmen August Pluger (R-TX) and Greg Landsman (D-OH), the bill removes certain requirements for biosimilars to be designated as interchangeable.

Specifically, it establishes a presumption that an approved biosimilar is interchangeable with the reference product without the need for additional evidence from the manufacturer and removes the applicable exclusivity periods for a first interchangeable biosimilar. ERIC believes that the "interchangeability" designation created in the BPCIA, which does not exist in other countries, is an artificial barrier that serves only to postpone market competition.

- Patients Deserve Price Tags Act (H.R. 5582)
    - Led by committee member Congressman John James (R-MI) and Congresswoman Maggie Goodlander (D-NH), the bill provides for improved price transparency, helping patients understand the actual cost of care, and extends reporting requirements across a range of health care providers, plans, and PBMs. The real prices that will be available under this bill will help plan sponsors to suss out where arbitrage is taking place in the drug supply chain.

- Healthy Competition for Better Care Act (H.R. 6248)
    - Led by Budget Committee Chairman Jodey Arrington (R-TX) with committee member Congressman Rick Allen (R-GA) as an original cosponsor, this legislation would improve fairness in contracting by allowing for enrollee incentives to choose high-quality and low-cost providers, and allows insurers and employers to contract with hospitals and providers without requirements to enter into additional contracts with other affiliated providers or hospitals.

This measure will ensure that plan sponsors can build their provider networks in a way that maximizes value for patients and exclude those sites of care where prices are inflated – including drug prices, as some hospital systems add unconscionable markups to drugs.

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

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

Furthermore, ERIC supports policies to address aspects of the drug supply chain that add unnecessary costs for employers and patients, such as:

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

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

- Transparency for Drug Wholesalers
    - Congress should consider requiring wholesalers to report their rate structure, including disclosure of net acquisition costs for each drug acquired, service fees, prompt-pay discounts, and realized margins to expose hidden spread pricing that inflates drug costs. This will allow for more transparency through the prescription drug supply chain.

Conclusion

In conclusion, thank you for this opportunity to share our views with the Committee. We are committed to working with Congress toward comprehensive solutions that promote competition and increase access to affordable medications. We look forward to working with the Committee to enact legislation addressing these critical goals, ensuring that large employers can continue to offer affordable health care coverage, including access to affordable drug options, to the tens of millions of Americans who depend on employer-sponsored coverage.

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Shaping benefit policies before they shape you.

Promoting Prescription Drug Affordability by Minimizing Middleman Arbitrage in the Supply Chain

ERIC supports a broad array of policy reforms to bring further transparency and lower costs to patients. Several of these measures have already been introduced and are ripe for consideration.

These bills are intended to spur faster adoption of and access to cheaper drug therapies, enhance transparency across stakeholders, and foster fairness in provider contracting:

- ***Biosimilar Red Tape Elimination Act*** **(H.R. 5526)**
  - Led by committee members Congressmen August Pluger (R-TX) and Greg Landsman (D-OH), the bill removes certain requirements for biosimilars to be designated as interchangeable. Specifically, it establishes a presumption that an approved biosimilar is interchangeable with the reference product without the need for additional evidence from the manufacturer and removes the applicable exclusivity periods for a first interchangeable biosimilar. The "interchangeability" designation created in the BPCIA, which does not exist in other countries, is an artificial barrier that serves only to postpone market competition.

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We encourage the committee to hold a markup on these bills this year and support

Furthermore, ERIC supports policies to address aspects of the drug supply chain that add unnecessary costs for employers and patients.

Congress should also consider the following policies to support and further address the lack of transparency and the prevalence of anti-competitive practices that are driving costs in the drug supply chain:

RFP Reform

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

Vertically Integrated GPOs and "Drug Companies"

- Congress should consider clarifying that CAA26 was intended to apply transparency to the entire PBM enterprise, including these affiliates. That should include revealing the "spread pricing" between what is paid to the manufacturer and what is retained by the PBM for "white label" drugs, as well as applying the rebate passthrough requirement to the various "fees" collected by GPOs.

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- Congress should consider requiring wholesalers to report their rate structure, including disclosure of net acquisition costs for each drug acquired, service fees, prompt-pay discounts, and realized margins to expose hidden spread pricing that inflates drug costs. This will allow for more transparency through the drug supply chain.