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Shaping benefit policies before they shape you.

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President and CEO

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Senate Finance Committee
Minority Staff
221 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients

Dear Senate Finance Committee Minority Staff:

Thank you for the opportunity to provide feedback on policies to lower drug prices for patients in the United States. We appreciate your attention to these areas and possible policy solutions to mitigate rising prescription drug costs being shouldered by employers as well as workers and their families.

The ERISA Industry Committee (ERIC) is a national advocacy organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. With member companies that are leaders in every economic sector, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans. ERIC member companies offer benefits to tens of millions of employees and their families, located in every state, city, and congressional district.

Below, we highlight a few of ERIC's topline policy recommendations that fit within Section II of the Request for Information for your consideration. More than 160 million Americans receive health insurance from their employers, and employers can and should be important partners to help forge affordability solutions. ERIC looks forward to working with you to advance our shared goal of affordable drugs for patients.

Section II: Enhancing Prescription Drug Affordability

Concerns with Applying Out-of-Pocket Caps to More Chronic Care Drugs in Medicare

While ERIC strongly supports ensuring affordable access to prescription drugs, we remind Congress: mandating out-of-pocket caps does not actually lower health care costs – it shifts them on to other people. ERIC remains concerned that imposing federally mandated cost-sharing requirements on employer-sponsored health plans sets a troubling precedent for future government mandates on benefit design.

Such mandates undermine employers' ability to tailor prescription drug benefits to the unique needs of their workforces and to manage health care costs through clinically appropriate benefit design.

Worse, out-of-pocket caps actually encourage branded drug manufacturers to charge higher prices, since patients will not directly experience the costs at the pharmacy counters. Congress should instead focus on policies that address the underlying drivers of prescription drug spending, including improving competition, increasing transparency throughout the supply chain, and ensuring that plan sponsors have the tools and flexibility needed to negotiate effectively on behalf of workers and families.

Pharmacy Benefit Managers (PBMs) and Fiduciary Accountability

For many years, ERIC has strongly supported pharmacy benefit manager (PBM) reforms that would promote transparency and ensure that negotiated savings benefit plan sponsors and patients – not middlemen. These include:

- Full transparency of PBM practices, including business arrangements, financial incentives, and formulary design.
- Banning spread pricing, which allows PBMs to profit from the difference between what they charge employers versus what they reimburse pharmacies.
- 100% pass-through to plan sponsors of rebates, discounts, fees, and other payments from drug manufacturers.
- De-linking PBM compensation from drug prices.

ERIC applauds Congress for enacting the *Consolidated Appropriations Act of 2026* (CAA), which includes significant reforms to the PBM industry and represents a major step forward for meaningful health care reform. However, more can be done to hold PBMs accountable.

To that end, ERIC strongly supports the *PBM Fiduciary Accountability, Integrity, and Reform (FAIR) Act* (S. 3549), which would clarify that PBMs performing services for ERISA-governed employer health plans must meet fiduciary standards when acting on behalf of the plan. PBMs should be required to act in the best interest of the plan, control costs for plan sponsors and patients, and be accountable for decisions that affect prescription drug access and affordability. ERIC encourages Senate Finance Committee members to support this reform.

Addressing Vertically Integrated GPOs and "Drug Companies"

Congress should clarify that the transparency requirements enacted in the *Consolidated Appropriations Act of 2026* (CAA26) apply across the full PBM enterprise, including vertically integrated affiliates such as group purchasing organizations (GPOs), private-label drug entities, "white label" products, and other related business arrangements. As PBM business models evolve, compensation can be shifted from traditional rebates into less transparent affiliate structures, creating additional layers between plan sponsors, manufacturers, and the true cost of prescription drugs.

To ensure meaningful transparency, Congress should direct the Departments of Health and Human Services and Labor to require disclosure of financial flows throughout the PBM ecosystem —not only transactions conducted directly by the PBM. This should include the difference between amounts paid to manufacturers and amounts retained by PBMs or affiliates for white-label or private-label drugs, as well as administrative, service, or other fees collected by PBM-affiliated GPOs that functionally replace traditional rebates.

The Committee should consider clarifying that CAA26 transparency and rebate passthrough requirements cover the full PBM enterprise, including affiliated GPOs and private-label drug arrangements. This would help prevent regulatory loopholes, improve accountability, and give employer plan sponsors the information needed to evaluate prescription drug spending and act as prudent fiduciaries for employees and beneficiaries.

Eliminating Conflicts of Interest for PBMs, Consultants, Brokers, and Other Vendors

Employers rely on brokers, consultants, and other advisors to help navigate complex PBM contracts and select vendors that best serve workers and their families. That trust is undermined when PBMs provide kickbacks, referral fees, or other undisclosed compensation to intermediaries in exchange for steering employer-sponsored health plan business to a particular PBM. The *PBM Kickback Prohibition Act* (H.R. 7895), supported by more than 50 employer and patient organizations, addresses this problem by prohibiting PBMs from paying intermediaries involved in PBM selection while preserving legitimate advisory services and market competition.[1]

This measured reform would restore integrity to PBM procurement by ensuring that recommendations are based on value, quality, and participant needs—not hidden vendor payments. We encourage the Senate Finance Committee to advance similar legislation.

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

RFP Reform and Net Effective Cost Disclosure

Congress should consider reforms to improve the integrity and transparency of broker- and consultant-led PBM requests for proposals (RFPs). RFPs should be structured to promote robust competition and give qualified PBMs a fair opportunity to compete on value, service, and total cost—not on selectively presented pricing components.

One such reform would be to facilitate the application of a net effective cost (NEC) bidding methodology for plan sponsors to use when comparing PBMs proposals submitted to plans through the RFP process. In this scenario, brokers and contractors would format each PBM bid to show the payor the projected total annual cost to the health plan using historical claims datasets and uniform assumptions. The NEC should reflect the plan's expected financial obligation after accounting for all pricing components.

Standardizing PBM procurement through RFP reform and NEC reporting would strengthen ERISA fiduciary oversight, improve transparency, promote meaningful competition, and better equip plan sponsors to select pharmacy benefit arrangements that serve the best interests of plan participants and beneficiaries.

Direct Contracting to Drive More Biosimilar Adoption

In November 2025, ERIC issued a white paper on "Innovative Employer Models: Incorporating Biosimilars Into Health Plan Drug Formularies" that describes how some ERIC member companies are rethinking pharmacy benefit design to support biosimilar utilization.[2] To overcome structural market distortions driven by traditional PBM business models, plan sponsors can achieve significant cost savings and improve patient outcomes by establishing direct contracting arrangements with retail pharmacy networks.

Traditional PBM models often rely on rebate-driven incentives that favor high-list-price reference biologics and create "rebate walls" that can block or delay access to lower-cost biosimilars. Direct contracting with retail pharmacy partners can help employers bypass spread pricing and opaque rebate retention structures while preserving convenient patient access to cost-effective biosimilar treatments.

We encourage the Senate Finance Committee to craft legislation that removes barriers to direct contracting arrangements, protects employers' ability to pursue lower-cost biosimilar strategies, and supports models that reduce prescription drug costs for patients.

[2] The ERISA Industry Committee. (2025). Innovative Employer Models: Incorporating Biosimilars into Health Plan Drug Formularies (Issue Brief)

Addressing Hospital Drug Markups: Increasing Transparency and Site-of-Care Accountability

Employer plan sponsors and workers also face significant prescription drug cost pressures when physician-administered drugs are furnished in hospital outpatient departments. Under the "buy-and-bill" model, hospitals acquire infused or injected medicines and then bill commercial plans for both the drug and its administration. Unlike Medicare, where payment for many physician-administered drugs is tied to average sales price (ASP), commercial payment rates are negotiated between insurers and providers and can vary substantially by provider and site of care. The Government Accountability Office has found that private payers often paid more than Medicare for physician-administered drugs, roughly 106 percent of Medicare's ASP.[3]

Recent RAND analysis provides particularly relevant evidence for employer-sponsored coverage. Examining 58 commonly administered drugs using commercial claims data from 2020–2022, RAND found substantial variation in commercial prices for administered drugs and reported that prices for administered drugs received in hospital settings averaged 2.8 times ASP across states.[4] RAND also found that one national payer's payments for infusions received in hospitals were approximately twice the prices paid in physician offices.[5] These findings are especially significant for employers because many physician-administered specialty drugs are covered under the medical benefit rather than the pharmacy benefit, and therefore may not be subject to the same rebate and pricing mechanisms applicable to traditional pharmacy claims. These payment differentials can be particularly consequential for high-cost specialty drugs and biologics. A percentage-based markup on a drug costing tens of thousands of dollars can translate into thousands of dollars in additional spending for a single course of treatment.

The Senate Finance Committee should direct the Congressional Budget Office (CBO) to examine the cost of physician-administered drugs under commercial employer-sponsored health plans, including the relationship between drug acquisition costs, negotiated reimbursement, facility fees, administration fees, site of care, and patient cost-sharing.

Additionally, the Committee should also consider policies that increase transparency into hospital acquisition costs, commercial reimbursement, and patient cost-sharing for provider-administered drugs; discourage percentage-of-charge or percentage-of-list-price payment arrangements that reward higher prices; and support site-neutral payment principles.

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[3] U.S. Government Accountability Office. (2016). *Physician-administered drugs: Comparison of payer payment methodologies* (GAO Publication No. GAO-16-780R).
[4] Whaley, C. M., Kerber, R., Wang, D., Kofner, A., & Briscombe, B. (2024). *Prices paid to hospitals by private health plans: Findings from Round 5.1 of an employer-led transparency initiative* (Report No. RR-A1144-2-v2). RAND Corporation.
[5] Ibid.

CBO has specifically identified site-neutral payment for hospital outpatient department services as a potential source of significant savings and concluded that expanding Medicare site-neutral payments would not cause hospitals to increase commercial prices through cost shifting.[6]

One possible reform in this area would be de-linking hospital reimbursement from prescription drug list prices, and instead paying hospitals for the labor costs associated with storing and administering a given treatment. Indeed, this is the only change that would actually change the market dynamics that currently encourage hospitals to choose the highest cost drugs, and manufacturers to focus on drugs that must be administered by a medical professional. On a similar vein, the Committee should consider banning drug "spread pricing" by hospitals, and instead pay only the acquisition cost of a given drug, and a dispensing fee that is not based on a drug's price.

Policymakers should also preserve employers' ability to use lower-cost, clinically sound specialty pharmacy and site-of-care management tools, including direct delivery arrangements, when those tools maintain patient safety and access. Greater accountability for hospital drug markups would complement PBM, wholesaler, and manufacturer reforms by ensuring that affordability efforts address every part of the prescription drug supply chain.

[6] Congressional Budget Office. (2024, August 1). *Answers to questions for the record following a hearing on hospital and physician consolidation and its impact on the federal budget*.

Oversight of Wholesalers

Wholesalers warrant greater congressional attention because of their central role in the prescription drug supply chain and their potential impact on overall drug spending. Manufacturers generally rely on wholesale distributors to store medications and deliver them to pharmacies. In 2022, wholesalers handled about 95 percent of all retail prescription drug sales.[7] The wholesale distribution market is highly concentrated, with three companies controlling roughly 95 percent of the market.[8] Eastern Research Group (ERG) found that wholesale margins totaled $23.4 billion in 2022, with brand-name drugs accounting for $14.1 billion of those margins and generic drugs accounting for $9.3 billion.[9]

ERG calculated margin dollars as the difference between net sales price and net acquisition cost, excluding the value of labor and services provided. Because generic drugs make up the vast majority of U.S. prescriptions, these figures suggest that brand-name drugs generate a disproportionate share of wholesaler margin dollars. This dynamic underscores why wholesaler compensation structures deserve the same scrutiny as other intermediary payment arrangements that may be tied to list prices rather than value, efficiency, or lower net costs for patients and plan sponsors. As with PBM compensation, Congress should consider whether wholesaler fees should be delinked from drug prices so compensation is based on bona fide distribution services rather than a percentage of a drug's list price.

Wholesalers also increasingly participate in vertically integrated arrangements. The Wall Street Journal has reported a major shift in the pharmaceutical supply chain in which the "Big Three" U.S. drug wholesalers have acquired oncology practices and other provider assets.[10] By acquiring physician groups, distributors can effectively secure customers for high-cost chemotherapy and specialty drugs within their own distribution networks. These arrangements may allow wholesalers to control more of the health care value chain, and create potential conflicts of interest or decisions adverse for patients related to drug purchasing and distribution.

ERIC encourages the Committee, in coordination with other committees of jurisdiction, to examine whether wholesaler compensation should be delinked from drug prices and whether additional antitrust scrutiny is warranted to address over-consolidation and vertical integration in the wholesale distribution market.

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[7] "Prescription Sales via Traditional Healthcare Distributors Increase." Pharmaceutical Commerce. October 2023.
[8] "3 Stocks to Watch in the Drug Distribution Industry". Keonhee Kim. Morningstar, April 2024.
[9] "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.
[10] "Why Drug Distributors Are Buying Cancer Specialists". David Wainer. The Wall Street Journal. September 27, 2024

Addressing Manufacturer Practices within the Patent System and Gaming of the Food and Drug Administration (FDA)

Many challenges in the prescription drug market stem from practices that undermine the balance Congress established in the 1984 Drug Price Competition and Patent Term Restoration Act, commonly known as Hatch-Waxman.
That framework was intended to reward meaningful innovation for a limited period while ensuring timely competition from generics and biosimilars; however, some manufacturers now use patent and regulatory strategies to delay competition, extend monopolies, and increase costs for plan sponsors and patients.

ERIC supports reforms that address patent abuse and gaming of FDA processes that reduce access to lower-cost alternatives. These practices can distort incentives, weaken competition, and threaten the long-term viability of generic and biosimilar markets.

ERIC also supports the following bills, organized by committee of jurisdiction, and encourages members of the Senate Finance Committee to support these targeted reforms:

Senate Judiciary Committee

- *Eliminating Thickets to Increase Competition (ETHIC) Act* (S. 2276) – This legislation would reduce patent thickets by limiting brand-name manufacturers to asserting one non-duplicative patent per patent group in certain litigation against generic or biosimilar competitors. This would streamline disputes, deter gamesmanship, and help lower-cost products reach the market sooner.

- *Skinny Labels, Big Savings Act* (S. 43) – This legislation would protect generic and biosimilar manufacturers from patent infringement claims when they use FDA-approved "skinny labels" that carve out patented uses. This would preserve a longstanding pathway for lower-cost competition while respecting valid method-of-use patents.

- *Prescription Pricing for the People Act of 2025* (S. 527) – This legislation would direct the Federal Trade Commission to examine anticompetitive practices and other trends across the pharmaceutical supply chain. The required report would include recommendations to improve transparency, prevent anticompetitive conduct, and ensure consumers benefit from cost savings.

- *Stop STALLING Act* (S. 1095) – This legislation would empower the Federal Trade Commission to deter objectively baseless citizen petitions filed to delay FDA approval of generic drugs or biosimilars. It would preserve the petition process for legitimate public health concerns while discouraging tactics designed primarily to block competition.

- *Preserve Access to Affordable Generics and Biosimilars Act* (S. 1096) – This legislation would prohibit anticompetitive "pay-for-delay" settlements in which brand-name manufacturers compensate generic or biosimilar competitors to postpone market entry. This reform would help ensure lower-cost alternatives reach patients and plan sponsors without unnecessary delay.

- *Interagency Patent Coordination and Improvement Act of 2025* (S. 1097) – This legislation would strengthen coordination between FDA and the U.S. Patent and Trademark Office to reduce misuse of patent filings. Better information-sharing would help ensure patent listings support genuine innovation rather than delay competition.

Health, Education, Labor and Pensions Committee

- *Expedited Access to Biosimilars Act* (S. 1414) – This legislation would streamline biosimilar approvals by reducing unnecessary clinical trial requirements while preserving FDA's rigorous safety and effectiveness standards. Lowering duplicative development costs can help bring biosimilars to market more efficiently.

- *Biosimilar Red Tape Elimination Act* (S. 1954) – This legislation would deem FDA-licensed biosimilars interchangeable with their reference products, subject to applicable exclusivity protections. Removing unnecessary interchangeability barriers would support pharmacy substitution where permitted by state law and promote greater biosimilar competition.

- *Medication Affordability and Patent Integrity Act* (S. 2658) – This legislation would strengthen coordination between FDA and the U.S. Patent and Trademark Office to improve patent integrity in prescription drug markets. These reforms would help balance incentives for innovation with timely access to lower-cost competition.

- *Ensuring Timely Access to Generics Act of 2025* (S. 3014) – This legislation would authorize FDA to deny citizen petitions submitted primarily to delay approval of generic or biosimilar products or that fail to raise legitimate scientific or regulatory concerns. This would reduce abuse of the petition process and accelerate access to lower-cost medicines.

Conclusion

Thank you for this opportunity to share our views. ERIC is committed to helping forge solutions that result in improved prescription drug affordability, transparency, access, quality, and safety for all Americans. We are confident that our policy recommendations can provide meaningful changes to the health care system. We look forward to working with you to further assist in this shared policy goal.

All the best,

James P Delfand