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CONGRESSIONAL TESTIMONY

Profits over Patients: The PBM Business Model under Scrutiny

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TESTIMONY BEFORE

UNITED STATES HOUSE OF REPRESENTATIVES
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Subcommittee on Health, Employment, Labor, and Pensions

TESTIMONY BY

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Chairman Allen, Ranking Member DeSaulnier, and members of the subcommittee. Thank you for inviting me to discuss legislation to codify the President's Great Healthcare Plan and put patients first.

My name is Hannah Anderson, and I lead Healthy America Policy at the America First Policy Institute (AFPI). We focus on patients-first health care, and like President Trump has declared -- transparency is a foundational piece in bringing about higher quality, lower prices, and a health care system that supports Americans taking back their health. I am also a former congressional staffer who was privileged to work with the members of this Committee and other House and Senate Committees on bipartisan health care transparency legislation. While many staff of the Committees have moved on to different jobs, I want to recognize Daniel Foster, of the Ranking Member's team, as part of the ten-person team negotiating the foundation of the price transparency work we get to discuss today.

I also want to first recognize the great work that the Congress has done to put patients first – namely, the bipartisan Lower Costs, More Transparency Act which passed the House on December 11, 2023. I worked on that legislation as a staffer with distinguished members of this Committee (and their staff) and it was a huge step forward for the necessary transparency of health costs. The Consolidated Appropriations Act, 2026 does require transparency into pharmacy claims costs for plans and this is critical for employers as they manage their prescription drug costs. These efforts have been bipartisan because the lack of transparency impacts us all.[1]

The Subcommittee on Health, Employment, Labor, and Pensions has the immense responsibility to oversee the administration and regulation of health care benefits of roughly 136 million Americans provided through about 2.6 million group health plans. These plans, as regulated by the Employee Retirement Income Security Act of 1974 (ERISA), give employers and unions great flexibility and authority to design health benefits for their employees to the greatest extent of the law. As health benefits have become more complex in design and by regulation, many group health plans have turned to service providers to help administer the costs of the health plan – aptly named "third-party administrators" of insurance, called "TPAs."

[1] https://www.americafirstpolicy.com/issues/analysis-of-title-vii-lowering-prescription-drug-costs-other-related-provisions

Over time, there have been a great number of these TPAs developed in order to support plan sponsors administer the health benefit to their employees or union members. And, to support plan sponsors in the complex design of these group health plans, brokers and consultants have come along to support Human Resources departments navigate a very broad world of options in plan design, cost, and administration.

These brokers and consultants – like Aon, Mercer, Lockton, or Segal – are just some of the wide variety of firms that come along and assist plan sponsors in the design of these health plans. Broadly speaking, they do great work and respond to the task at hand of coordinating benefits for employers and their employees. But the perverse incentives that exist in the market have turned their attention from the end user – the patient—to a different part of the business-to-business transaction. Major consulting firms, insurance brokers, PBMs, and their financial relationships, have systematically compromised the advice that employer-sponsored health plans, including union Taft-Hartley funds, receive on prescription drug benefits.

I. How the PBM–Consultant Financial Relationship Works

As this Subcommittee is familiar with, PBMs are middlemen between prescription drug companies and group health plans, often managing formularies, negotiating rebates from drug manufacturers, and reimbursing pharmacies on behalf of health plans.[2] Plan sponsors – the employers or unions – typically hire benefits consulting firms or brokers to evaluate PBMs, run requests for proposals (RFPs), negotiate contracts, and provide ongoing oversight.

The problem that the Subcommittee is considering, and the President's Great Healthcare Plan addresses, is that large consulting firms have developed multiple revenue streams sourced from both the clients they advise and from their contracted PBMs. According to a yearlong investigation published in June 2023, consulting firms can collect at least $1 per prescription from the largest PBMs, with fees ranging as high as $5 per prescription in "extreme cases".[3] Consulting firms and brokerages can also receive per-covered-employee fees, per-member fees, and shares of the rebates PBMs extract from pharmaceutical manufacturers. As the investigation notes, as prescription drug

[2] https://www.americafirstpolicy.com/issues/middlemen-favor-unaffordable-prescription-drugs
[3] https://www.statnews.com/2023/06/20/pbms-consulting-firms-investigation/

expenditures push towards a trillion dollars, perverse incentives potentially divert billions of dollars out of a health system intended to support patients.[4]

Jon Levitt, of Frier Levitt, described these perverse incentives bluntly during the investigation:

> *"The broker not only gives bad advice to the employer that's in the broker's self-interest, but the broker also allows the big PBM to write crazy terms into a contract. It's unethical. It's beyond unethical."*

The National Alliance of Healthcare Purchaser Coalitions, in its 2023 PBM Misalignment Playbook, characterized these advisors not as "buyer's agents" but as "seller's agents." These advisors are consultants whose business models are as dependent on, or more dependent on, PBM compensation than on client fees.[5] In its survey of employers and health plans, the playbook listed a disturbing pattern where "established, preferred providers with direct and potentially conflicted compensation from PBM" become effectively embedded in the PBM selection process, with firm profitability driving advisor priorities rather than plan sponsor interests. The preferred providers were riddled with gag clauses, formulary restrictions, and audit limitations. Health plans, with their fiduciary obligation to the participants and beneficiaries, are hamstrung from the beginning with contract terms from these preferred service providers.

The consequence of this financial inversion is that vendor selection becomes "vendor placement." Or, in other words, the consulting firm is not finding the best PBM for the client; it is placing the client with the PBM that pays the consultant the most. For union health plans operating under Taft-Hartley trusts, or group health plans maintained as an employee welfare benefit plan, this is a direct violation of the plan fiduciaries' ERISA obligations, which require that plan assets be spent exclusively for the benefit of participants and beneficiaries.

[4] https://pubmed.ncbi.nlm.nih.gov/40263109/
[5] https://ncbch.net/files/PBM%20Playbook--NationalAlliance-NCBCH_2023_A.pdf

II. In Real Life: Patients Paying More for Perverse Incentives Between Broker and PBM

The Johnson & Johnson / Aon / Express Scripts Case

The most highlighted example of a consulting firm receiving PBM compensation while supposedly acting in a plan sponsor's interest involves Johnson & Johnson, its broker Aon, and Express Scripts (ESI). In a class action filed in 2024 (*Lewandowski v. Johnson & Johnson*), plaintiffs alleged that J&J breached its fiduciary duties in selecting ESI as its PBM because it allowed the process to be "guided or managed" by broker Aon, who received compensation from ESI in exchange for steering J&J to ESI.[6] At AFPI, we have written that this is a conflict of interest under ERISA.[7] The complaint alleged that because of this conflicted advice, J&J's plan paid $10,239.69 for a 90-day prescription product that was available for $28.40, a markup of more than six times the PBM's own reimbursement cost and 360 times for what a patient could have paid without using insurance. According to the complaint, the plan paid six times as much as ESI paid pharmacies for the same drugs. When this information is undisclosed to the plan sponsor, they may not be scrutinizing PBM contract terms as closely as the plan should. Amendments made pursuant to the Consolidated Appropriations Act, ERISA requires written disclosure of all direct and indirect compensation a service provider receives while servicing a plan and plaintiffs alleged J&J failed to appreciate or address this conflict.

The Wells Fargo / Express Scripts Case

A companion lawsuit (*Navarro v. Wells Fargo & Co.*) alleged that Wells Fargo paid an excessive amount in administrative fees to ESI, fees the plaintiffs argued greatly exceeded what comparable or even smaller plans paid, constituting a prohibited transaction under ERISA.[8] The Wells Fargo case, filed shortly after the J&J case, was dismissed in part because plaintiffs failed to demonstrate Article III standing. They could not show a concrete, traceable injury caused by the alleged misconduct. However, the complaint detailed how Wells Fargo employees paid $10,000 for a drug that cost $650-$900 when paying cash at the pharmacy counter.

[6] https://litigationtracker.law.georgetown.edu/litigation/lewandowski-v-johnson-and-johnson/
[7] https://www.americafirstpolicy.com/issues/middlemen-favor-unaffordable-prescription-drugs
[8] https://www.documentcloud.org/documents/25868096-wells_fargo_erisa_complaint/

JPMorgan ERISA Class Action (2025)

In March 2025, participants in JPMorgan's employee health plan filed an ERISA class action (*Stern v. JPMorgan Chase & Co.*, No. 25-2097) with the allegation that the plan paid the PBM approximately three times as much as the PBM paid pharmacies for the same drugs.[9] The complaint asserted that JP Morgan contributed to the breach of fiduciary duty by using spread pricing, adding undisclosed fees, and a failure to put PBM services out to competitive bid. The class action accuses JPMorgan of using a "fundamentally flawed" process in hiring CVS Caremark to manage the prescription drug benefit, and calls into question whether CVS Health, as an investment banking client of JPMorgan, influenced the hiring and reimbursement decisions by JPMorgan. The complaint highlighted the drugs teriflunomide (a treatment for multiple sclerosis) and imatinib (a treatment for leukemia), where patients reportedly overpaid, by 38,000% and 8,600%, respectively, because of a lack by the employers to assess and audit the decisions made by their PBM and benefit consultants.[10] While the court partially dismissed the case in March 2026, it allowed the ERISA prohibited-transaction claim to proceed.

Chicago Plumbers Local 130 Union / Express Scripts RICO Lawsuit (2026)

In one of the most significant union-specific cases, the Plumbers' Welfare Fund, Local 130, which provides health benefits for members of the Chicago-based union, filed a proposed class action RICO lawsuit in February 2026 against Express Scripts, Cigna, Ascent Health Services, and Evernorth.[11] The complaint says that despite the union health fund amending its contract effective January 1, 2019, to require ESI to pass along the full amount of rebates and administrative fees paid by drug companies, Express Scripts developed an "elaborate, fraudulent scheme" to avoid this requirement. ESI diverted what should have been rebates through Ascent Health Services, a Switzerland-based company formed as a group purchasing organization (GPO), relabeling the payments from drug manufacturers as "fees" rather than rebates. Because the contract required pass-through of rebates but not fees, ESI retained billions of dollars that should have flowed to the union health fund and other plan clients. As summarized in the complaint filed by Bernstein Litowitz Berger & Grossmann: "Defendants concealed these bribes and kickbacks by arranging for each drug company to funnel the

[9] https://www.reuters.com/sustainability/boards-policy-regulation/jpmorgan-chase-employees-may-sue-over-high-drug-costs-premiums-judge-rules-2026-03-09/

[10] https://www.hrgrapevine.com/us/content/article/2026-03-13-wake-up-call-for-employers-as-judge-rules-jpmorgan-staff-may-sue-over-high-drug-costs

[11] https://www.blbglaw.com/cases-investigations/express-scripts-pbm

payments to Ascent and misclassifying them as [fees].” The lawsuit seeks to recover these funds on behalf of all ESI PBM customers nationally.

III. Big Three Consulting Firms and Their Drug Purchasing Coalitions

Three of the largest benefits consultants, Aon, Mercer, and Willis Towers Watson (WTW), each have a prescription drug purchasing coalition that can aggregate employer purchasing volume to negotiate better PBM contracts. These coalitions partner with the Big Three PBMs: CVS Caremark, Express Scripts, and OptumRx. This creates a revenue stream for the consulting firms that work with them. For example, when a consulting firm forms a “collaborative” with a PBM, it effectively functions as a reseller, not an independent advisor. As pharmacy benefit analytics firm Truveris noted: “They have moved far away from their initial independence by partnering almost exclusively with the Big 3 PBMs – CVS, ESI, and Optum. These group purchasing contracts provide a lucrative revenue stream for the consulting firms to consider other group contracts or innovations like specialty carve-outs.”[12]

The conflict is structural and self-perpetuating. Because the consulting firm profits as drug spending increases (earning more per prescription as volume grows), it has an inherent conflict in recommending specialty drug carve-outs, pass-through PBMs, or other arrangements that would dramatically reduce overall pharmacy spend. An employer who wants to design a unique benefit arrangement would unknowingly hit a wall with their consultant, who is secretly profiting from a status quo arrangement with the PBMs.

A 2021 Department of Justice antitrust review of Aon's proposed acquisition of Willis Towers Watson raised explicit concerns about the firms' combined “pharmacy coalition” services and the joint volume of drug purchasing arrangements they would control. Aon ultimately proposed to divest its pharmaceutical coalition services as a condition of addressing DOJ concerns, and the merger ultimately failed to close.[13]

IV. Anti-Competitive Behavior Between PBMs, Consulting Firms, and Plans

In addition to referral fees, PBMs can punish or marginalize independent advisors who might challenge PBM profit structures. Some examples may include:

[12] https://truveris.com/misaligned-incentives/
[13] https://www.justice.gov/atr/case/us-v-aon-plc-and-willis-towers-watson-plc

Gag Clauses and Information Suppression

PBMs have inserted gag clauses in contracts that prevent pharmacists from disclosing lower-cost alternatives to patients,[14] prevent auditors from commenting on issues outside narrow "contract compliance" questions and restrict brokers and consultants from fully analyzing competitor PBMs. Plan sponsors who seek fully independent audits often find that PBM contracts define "qualified auditors" in ways that functionally exclude anyone with expertise or independence to identify significant overcharges. Reforms passed by this Committee have attempted to correct this behavior, but these gag clauses remain.

Coercive Data Portal Fee Structures

PBMs have charged data portal fees with an explicit implicit threat: if a pharmaceutical manufacturer or consulting firm did not participate at the increasing fee level, they were disadvantaged by being placed on a lower formulary tier.[15] These fees were, in several instances, identified as generating minimal value while effectively acting as extraction mechanisms backed by the implicit threat of formulary exclusion. In addition, according to Nephron Research, the data and data portal fee levels collected from survey respondents to the broader commercial market, estimated that data and data portal compensation has grown from near zero in 2018 to $968 million in 2022.[16]

Offshore Rebate Aggregators to Evade Disclosure

PBMs have formed offshore group purchasing organizations (GPOs), acting as rebate aggregators, to avoid transparency requirements. The FTC noted that these rebate aggregators, such as Express Scripts' Ascent Health Services (in Switzerland), were formed partly to "retain revenue from incremental fee structures" that do not pass onto a PBM client.[17,18] As outlined in FTC's 2026 settlement with Express Scripts, one of the requirements was that Ascent relocated all rebate-

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[14] CAA 2021 included a provision that allows pharmacists to disclose the cash price of the drug at the pharmacy counter.

[15] https://hntrbrk.com/pbmgpo/

[16] https://cdn.ymaws.com/www.wsparx.org/resource/resmgr/legislative_session/2024/pbm_campaign/nephron_pbm.pdf

[17] https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[18] https://www.cov.com/en/news-and-insights/insights/2024/07/federal-trade-commission-asserts-significant-anticompetitive-harms-in-interim-staff-report-on-the-pharmacy-benefit-manager-industry

negotiating activities from Switzerland to the United States.[19] The settlement also requires Express Scripts to eliminate spread pricing, decouple rebates and fees from list price, and submit to monitoring for 10 years (with key operational changes due by January 1, 2028). In addition, the bipartisan, Title VII of the Consolidated Appropriations Act of 2026, required that all remuneration, generated by pharmacy benefit management services and 'applicable' group purchasing organizations (the rebate aggregators), should be passed along to the group health plan.[20]

CVS Caremark's Suppression of Independent Pharmacy Hubs

In January 2026, the U.S. House Judiciary Committee's Antitrust Subcommittee released an interim report finding that CVS Health and CVS Caremark may have engaged in anticompetitive conduct. They found that CVS might have restricted independent pharmacies from working with third-party digital pharmacy "hub" services, like BlinkRx.[21] According to internal CVS documents obtained by the committee, CVS identified these hubs as "competitive threats", failed to develop alternatives, and then shifted strategies. They started to modify its pharmacy provider manual to create compliance ambiguity, initiating "pretextual audits", and issuing cease-and-desist letters to pharmacies working with hubs. Since CVS Caremark controls roughly 30% of the PBM market, exclusion from the Caremark network could completely end a pharmacy (like a rural independent pharmacy) from serving nearly one-third of insured Americans.[22]

Michigan AG: Express Scripts and Prime Therapeutics Price-Fixing Conspiracy

In 2025, the Michigan Attorney General filed a lawsuit against Express Scripts and Prime Therapeutics, saying that they fixed prices which then suppressed reimbursement rates to independent and community pharmacies, restricted access to medications, and eliminated competition in violation of antitrust laws.[23]

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[19] https://www.ftc.gov/news-events/news/press-releases/2026/02/ftc-secures-landmark-settlement-express-scripts-lower-drug-costs-american-patients
[20] https://www.congress.gov/bill/119th-congress/house-bill/7148/text
[21] https://judiciary.house.gov/sites/evo-subsites/republicans-judiciary.house.gov/files/2026-01/2026-01-21-When-CVS-Writes-the-Rules-How-CVS-Protects-Itself-from-Innovation-and-Competition.pdf
[22] https://www.duanemorris.com/alerts/house_judiciary_committee_report_alleges_anticompetitive_pbm_conduct_targeting_pharmacy_0126.html
[23] https://www.michigan.gov/ag/news/press-releases/2025/04/29/ag-nessel-files-lawsuit

GoodRx Price-Fixing with PBMs

Multiple class action lawsuits were filed in 2025 saying that GoodRx, CVS Caremark, Express Scripts, MedImpact, and Navitus, engaged in an illegal horizontal price-fixing agreement through GoodRx's "Integrated Savings Program" (ISP). The ISP algorithm, in PBMs' claims-processing systems, caused each PBM to pay pharmacies the lowest reimbursement rate offered by any competitor PBM in the GoodRx network. This effectively enabled the PBMs to agree not to outbid each other for pharmacy business and suppress reimbursements to independent pharmacies while charging pharmacies per-prescription access fees.[24]

FTC Report: Formulary Manipulation to Capture Rebates on High-Cost Insulin

The FTC sued CVS Caremark, Express Scripts, and OptumRx in 2024 saying that the "Big Three" violated the FTC Act by excluding low-list-price insulin products from their commercial formularies in favor of high-list-price insulin products, allegedly to capture larger rebates from manufacturers of the high-priced versions. According to the suit, the plan designs implemented by these PBMs failed to pass discounts and rebates to patients at the pharmacy counter, meaning patients paid high out-of-pocket costs based on the inflated list prices even as the PBMs took the rebates.[25]

V. The RFP Process

PBMs maintain influence over the selection process through what the National Alliance has called "biased and conflicted Requests for Proposal" processes. The structural flaws include:

- **Limiting competition to the Big Three.** Standard RFP processes typically invite only 3–5 PBMs and require respondents to meet pre-defined parameters that can effectively favor CVS Caremark, Express Scripts, and OptumRx.
- **Undefined key terms.** PBMs each define terms like "generic," "specialty," "brand," and "MAC pricing" based on their own determinations, giving them great discretion over which drugs are included in pricing guarantees.
- **No focus on net drug cost.** Standard RFPs focus on discount percentages off AWP (Average Wholesale Price) and rebate guarantees, instead of on actual per-member-per-

[24] https://www.kellerrohrback.com/news/goodrx-pbm-price-fixing
[25] https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescription-drug-middlemen-artificially-inflating-insulin-drug-prices

month drug cost, making it virtually impossible to compare the true net cost of different PBM arrangements.

- **Consultant self-evaluation.** Consulting firms operating their own purchasing coalitions evaluate those coalitions in client RFP processes, creating a direct conflict.
- **Formulary and utilization management excluded from scoring.** Consultants' standard RFP spreadsheets typically do not score value-based formularies, lower prior-authorization approval rates, or willingness to drive biosimilar adoption — exactly the areas where PBMs can mask the highest margins.

TransparentRx, a pharmacy benefit advisory, documented how PBM staff analysts are specifically tasked with identifying "levers left available to them via opaque contract language," with margins on pharmacy spend potentially ranging from 10% to 30% of final plan cost when all hidden revenue streams are included, all enabled by contract terms brokers failed to close.[26]

VI. From "Buyer's Agent" to "Seller's Agent"

When a consultant receives undisclosed compensation from a PBM, it no longer is the buyer's agent for the health plan and becomes, functionally, a seller's agent for the PBM. The plan sponsor continues to pay consulting fees assuming it has an independent advisor, while in reality, the PBM controls the economic incentives driving advisor behavior.

Broker commissions in health insurance typically range from 3% to 6% of total premium spend. For a small business looking to purchase $250,000 worth of premiums, that's up to $15,000. When it's a large business looking to purchase $1.5 million worth of premiums, that's up to $90,000. When undisclosed PBM payments, like per-prescription fees, per-member fees, coalition override payments, and rebate shares are layered on top, the total compensation to the advisor from PBM-side sources can dwarf what the employer directly pays. The consequences are cascading:

- The broker gives advice favoring PBM contract terms that maximize PBM revenue (spread pricing, specialty steering, changes in utilization management), because broker income grows with pharmacy spend;
- The broker allows the PBM to write opaque (or even exploitative) contract terms knowing those terms won't be challenged;

[26] https://transparentrx.com/conventional-pbm-rfp-process-is-flawed

- The plan pays more for drugs, which translates into higher premiums for workers, stagnant wages, and reduced medical benefit – all which keep Americans from staying healthy.

Independent PBMs and pass-through pricing models are not presented as options, because they would reduce the overall revenue available to both the broker coalition and the incumbent PBM.

VII. Addressing the Problem: What the Trump Administration Has Done

The Trump Administration has acknowledged this problem as well: how are unions, employers, and other plan sponsors supposed to design and develop robust, attractive health benefit packages without an understanding of the factors that might be directing dollars behind the scenes? Under the leadership of this Committee, and colleagues at the Senate Health, Education, Labor, and Pensions Committee, the Consolidated Appropriations Act of 2021 (CAA) inserted bipartisan language into ERISA's Section 408(b)(2)(B) which requires disclosure of indirect and direct compensation of brokers and consultants in order for a plan sponsor to uphold their fiduciary obligation to the participant and beneficiary.[27] President Trump signed the provision into the law on December 27, 2020, with a whole host of bipartisan, patients-first, transparency measures under the CAA.

The Trump administration took this issue up again, issuing Executive Order 14273 *Lowering Drug Prices by Once Again Putting Americans First*, requiring the Department of Labor (DOL) to propose regulations to improve transparency into the direct and indirect compensation received by PBMs. In January 2026, the DOL proposed PBM disclosure rule saying, "Consulting firms and brokerages reportedly may receive payments on a per prescription or per covered employee basis, or they may share in...[the rebates that PBMs negotiate with manufacturers]."[28] The proposed rule requires providers of PBM services to "provide specific initial and semiannual disclosures to plan fiduciaries of employer-sponsored self-insured group health plans" as well as requiring PBMs to allow plan fiduciaries to audit the disclosures to verify their accuracy.

To complement this, the Committee advanced a long-awaited, bipartisan codification of this requirement in Title VII of the Consolidated Appropriations Act of 2026 (Title VII).[29] As I

[27] https://www.congress.gov/bill/116th-congress/house-bill/133/text
[28] https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/proposed-pharmacy-benefit-manager-fee-disclosure-rule
[29] https://www.congress.gov/bill/119th-congress/house-bill/7148/text

discuss further in AFPI's *Analysis of Title VII: Lowering Prescription Drug Costs & Other Related Provisions*, now PBMs, consultants, and brokers will be required to report any direct or indirect remuneration to the health plan.

VIII. The Great Healthcare Plan and Ending Conflicts of Interest which Hurts Patients

To further address these conflicts of interest, a major tenet of the President's Great Healthcare Plan is to "end the kickbacks paid by pharmacy benefit managers to the large brokerage middlemen that deceptively raise the cost of health insurance." As documented throughout my testimony, this is not a problem of a few bad actors, but of a structural problem pervasive throughout the healthcare system. At AFPI, we advocate for patients-first policies that promote a flourishing healthcare economy that works first for patients. The perverse incentives that exist between brokers, consultants, and PBMs are anti-competitive and inconsistent with a healthcare economy that serves the patient first. President Trump is the most pro-patient President in my lifetime, and he understands what needs to be done to end the perverse incentives that hurt patients and make care more expensive.

On a bipartisan basis, this committee has championed pro-patient, pro-transparency legislation, and continues the good work through Chairman Allen's legislation, the *PBM Kickback Prohibition Act*. The legislation would amend ERISA to prohibit PBMs from paying referral fees to brokers, consultants, advisors, or similar intermediaries in exchange for directing employer health plan or insurer business to the PBM. The legislation does this by amending ERISA's prohibited transaction provisions.

Patients-first is not just a tagline, but a requirement under ERISA. Businesses and unions rely on health benefits offerings as a powerful employee recruitment and retention tool, and in turn, millions of Americans rely on union or employer-sponsored healthcare for their health benefits. This Committee, through Congressman Allen's legislation, can take a huge step forward to protect health benefits for the American worker.

In conclusion, thank you for your time today and I look forward to answering questions from the esteemed members of this Committee as to how we can provide for a patients-first healthcare system. If enacted, the President's Great Healthcare Plan would lower costs, increase transparency, and Make Americans Healthy Again.