



Midwest Business Group on Health

The PBM Contracting Reset: What Employers Need To Do Now

Because of the [Federal Trade Commission \(FTC\)](#)^{1,3} and the [U.S. Department of Labor \(DOL\)](#)² findings on PBMs, employers should negotiate Pharmacy Benefit Manager (PBM) contracts that:

- Guarantee full financial transparency
- Require verifiable and traceable pricing and formulary decisions
- Mandate clinically aligned and evidence-based utilization management
- Preserve employer control over plan design
- Establish a clear specialty pharmacy strategy
- Provide for fiduciary oversight



In early 2025, the FTC launched *The Second Interim Staff Report on Prescription Drug Middlemen*³ containing a [graphic](#) that represented the six largest PBMs who manage nearly 95% of U.S. prescriptions. Each is part of a much larger corporation that owns a top 10 health insurer, along with pharmacies, physician practices, and other healthcare entities. The FTC has characterized these organizations as “vertically integrated”, reflecting their control across multiple segments of the healthcare and pharmaceutical supply chain.

For many years, employers and payers have sought legislative and regulatory action to increase insight and regulate how PBMs generate revenue, negotiate rebates, reimburse pharmacies, and manage prescription drug benefits on behalf of employers, health plans, and government programs. In response, the Consolidated Appropriations Act of 2021 (CAA 2021)⁴ included provisions reforming how group health plans contract with PBMs to enhance transparency, strengthen fiduciary oversight, and ensure plan fiduciaries have the information needed to assess PBM compensation structures and business practices.

For years, employers have operated within a healthcare marketplace where critical information on pharmacy benefits' pricing, rebates, and formulary decision-making remained largely opaque and inaccessible. Going forward, plans that achieve both cost savings and high-quality care will be those that actively steer members through intentional guidance, apply clinical rigor, demand data transparency, and ensure tight alignment with their PBMs. A passive approach is no longer sufficient – employers must take an active, strategic role to meaningfully improve pharmacy cost trends and outcomes. The time is now!

– Cheryl Larson, President & CEO, MBGH



This Action Brief examines the key barriers employers face when contracting with pharmacy benefit middleman, and how recent legislation may represent a step in the right direction towards greater transparency. However, significant work remains to ensure employers can secure the best possible pricing and effectively support the healthcare needs of their employees and families.

Throughout this brief, look for the lightbulb icon highlighting employer perspectives, insights, and recommendations from leading health benefits leaders. Watch for the Employer Action Steps featured throughout the document (first link below), which provide practical actions employers can take to address key challenges and opportunities.

Also explore the PBM Contracting Guidance (second link below). This resource offers practical strategies to help employers strengthen oversight, improve transparency, enhance accountability, and regain greater control of their pharmacy benefit programs.

Quick Links



Employer
Action Steps



PBM Contracting
Recommendations

The legislation, together with the DOL's proposed PBM fee disclosure requirements², introduced new reporting and transparency obligations related to PBM compensation reporting, rebate transparency, spread pricing disclosures (*the health plan pays more for a drug than the PBM reimburses the pharmacy and the PBM retains the difference as profit*), claw-backs (*PBMs recoup money from pharmacies weeks or months after claims are paid through fees, performance metrics, or pricing adjustments*), fiduciary evaluation of PBM arrangements, and other indirect compensation mechanisms that materially affect self-insured employers' total pharmacy costs.

While this represents an important step toward greater transparency and accountability, it does not fundamentally alter existing PBM profitability, market concentration, or impact employer negotiating leverage. Instead, it forces visibility into a system that has long operated with limited transparency and highly complex financial arrangements.

In addition, transparency alone does not determine whether PBM arrangements are appropriate, aligned with fiduciary obligations, or structured to optimize member outcomes and total cost management. As a result, employers must start or continue to actively evaluate contract terms, financial incentives, formulary strategies, specialty pharmacy arrangements, and clinical management practices to determine whether their PBM arrangements truly serve the best interests of the plan and its members.

Are Double-Digit Cost Savings Over?

The days of achieving double-digit pharmacy savings simply by changing PBMs or renegotiating contracts are largely over. Most of the obvious opportunities such as greater purchasing scale, rebate optimization, and contract restructuring have already been captured. As the market has matured, PBM changes that once delivered significant savings now tend to produce only modest improvements.

Today, the greatest opportunity is not in how drugs are priced, but in how they are selected, prescribed, managed, and monitored over time. Pharmacy spending is driven by thousands of clinical decisions involving drug choice, treatment sequencing, dosing, duration of therapy, adherence, and site of care. Yet many employers continue to focus primarily on rebates, discounts, and contractual guarantees while paying less attention to the clinical management practices that ultimately determine utilization and cost.

This challenge is compounded by the realities of the PBM business model. Formularies, prior authorization programs, specialty pharmacy arrangements, and network designs may appear clinically appropriate, but they are not always economically neutral. PBM incentives can influence utilization patterns, particularly in specialty pharmacy. Transparency is important, but disclosure alone does not ensure alignment between PBM actions and employer goals.

As a result, pharmacy benefit management must evolve from contract administration to active stewardship. The employers who generate value will be those who treat pharmacy as an actively managed system, not a periodically negotiated contract. The implication is direct: don't assume PBM programs are sufficient – validate them, govern them, and hold them accountable for outcomes.

The most effective pharmacy strategies today rely on disciplined clinical management: optimizing drug selection, enforcing evidence-based dosing and duration guidelines, closely overseeing specialty drug utilization, and proactively addressing emerging cost and quality issues. As traditional savings opportunities diminish, employers that achieve lasting value will be those that retain their rights via properly executed contracts and that treat pharmacy benefits as an actively managed clinical program, not simply a contract that is periodically renegotiated.

The days of double-digit savings through RFPs are over. Employers need to shift their focus to optimizing clinical decisions – therapeutic interchange, dose optimization, specialty oversight, and adherence – over sole reliance on incremental channel guarantees. Don't assume PBM programs are sufficient; validate them.

Transparency alone will not immediately reduce costs, but it will raise employer accountability. Passive oversight is increasingly difficult to defend when employers are expected to approve and govern PBM strategy, pricing, and formulary decisions.



General pharmacy cost trend is not a budget nuisance – it is a compounding financial force. Most employers underestimate how quickly “acceptable” trend becomes structurally unaffordable.



We recently did an RFP and had an independent party review our PBM contract because we are continuing with the same PBM. That is a great time to reinforce the reiteration of the contract.

What Does the New PBM Legislation Mean for Employers – Reporting & Transparency Requirements

As noted previously, the Consolidated Appropriations Act of 2021 (CAA 2021)⁴ significantly reforms employer-sponsored pharmacy benefit programs. These federal standards are intended to strengthen fiduciary oversight by ensuring plan sponsors have access to detailed PBM compensation and pricing information necessary to meet their obligations under ERISA. The following section outlines key details of what the reform specifically does and does not do.

What PBM Reform Does

- Requires greater disclosure of PBM compensation, fees, rebates, and other revenue streams tied to pharmacy benefit administration while expanding reporting obligations related to prescription drug costs, formulary management, and rebate arrangements
- Increases employer and payer visibility into PBM contracting structures, financial practices, and broader compensation flows including spread pricing and rebate dynamics across the pharmacy supply chain
- Enhances federal oversight and auditing authority for PBM activities within employer-sponsored and government-funded health plans
- Creates additional reporting requirements intended to identify conflicts of interest and improves transparency into pricing and financial arrangements
- Raises fiduciary expectations for employers, plan sponsors and benefits advisors by increasing access to data while simultaneously elevating the responsibility to interpret, validate, monitor, and act on that information appropriately

Achieving meaningful improvement will depend less on disclosure alone and more on active governance. Employers should implement contracts that track total PBM payments, enforce meaningful audit rights, independently validate pricing and rebate arrangements, and secure direct access to claims-level and formulary data.

Expanding transparency requirements are likely to push greater compliance, documentation, and financial scrutiny downstream across the healthcare supply chain. Employers and other market participants will increasingly be expected to validate and monitor arrangements that historically lacked visibility.



What PBM Reform Does Not Do

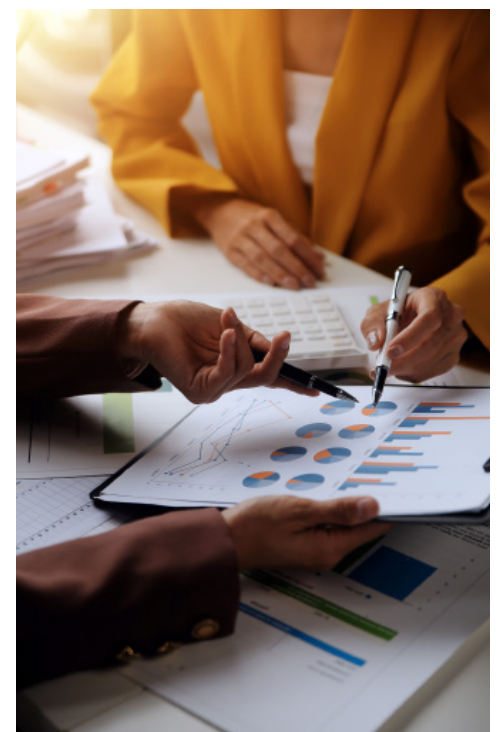
- Change the underlying PBM business model or its core misaligned financial incentives
- Eliminate rebate-driven formulary strategies, spread pricing practices or other forms of margin optimization
- Dismantle vertical integration among PBMs, insurers, specialty pharmacies, and group purchasing organizations (GPOs)
- Expose all indirect revenue streams, affiliate relationships, or complex contractual arrangements across the pharmacy supply chain



Some believe market share drives the best deals, but I believe you can find savings with the proper structuring of your contract.



We went through our contract last year and found some significant savings that we'll see over the next 3 years, for every single year, because of that specific contract review. So, it certainly was a value add for us.



- Guarantee lower drug costs, improved affordability, or better clinical outcomes for employers, patients, or plan sponsors
- Restore employer negotiating leverage or ensure optimal net pricing without active contract management and oversight
- Replace the need for independent auditing, fiduciary review, or ongoing data validation and performance monitoring
- Require PBMs to prioritize lowest net cost or most clinically appropriate formulary design over contractual or financial incentives
- Eliminate conflicts of interest embedded in formulary design, utilization management, or specialty pharmacy steering practices
- Prevent PBMs from shifting revenue generation across alternative channels (e.g., administrative fees, service arrangements, or affiliate structures) as scrutiny increases
- Reduce market concentration or structural consolidation within PBMs and their affiliated entities

Transparency-related reform increases disclosure and visibility, but it does not inherently create accountability. Employers still bear responsibility for determining whether contractual arrangements are competitive, appropriate, and aligned with plan objectives.

What to Watch For

Ultimately, the new legislation provides employers with better information – not automatic protection. Its effectiveness depends on how aggressively employers and plan sponsors use transparency tools to negotiate contracts, validate pricing, monitor performance, and enforce fiduciary alignment across the pharmacy benefit ecosystem.



Current PBM reform has not “fixed” the system – it has handed employers a flashlight and how we use the information matters!

Now What?

PBMs are highly adaptive financial intermediaries that can extract revenue across different channels while preserving or expanding their margins and remaining compliant with evolving disclosure rules. This means transparency alone is unlikely to disrupt the broader market dynamics, consolidation trends, or vertically integrated structures that continue to drive revenue throughout the pharmacy benefit ecosystem. It will also not compensate for misaligned incentives or certain market structures as PBMs operate across multiple revenue streams including rebates, fees, network differentials, and affiliated entities (e.g., wholesalers, specialty pharmacies, rebate aggregators/GPOs).

For employers, legislation should be viewed as an important visibility and governance tool and not a complete solution. Effective oversight will still require stronger contracting strategies, independent analytics, audit rights, fiduciary accountability, and ongoing evaluation of PBM alignment with employer and member interests.

Ultimately, the new transparency requirements provide employers with better information—not automatic protection. Transparency has increased visibility into pharmacy benefit arrangements, but it has not changed the underlying economic incentives that drive behavior across the pharmacy supply chain. The system has not fundamentally changed; it has become more visible.

What was once hidden is now disclosed, but disclosure alone does not improve performance. It raises expectations and creates new responsibilities for employers and plan sponsors.

As a result, access to information should not be mistaken for control. Contracts, definitions, and oversight ultimately determine where value accrues and whether pharmacy benefit decisions align with employer interests. The success of these reforms will depend on how actively employers use the information available to them.

Employer Action Steps

- Negotiate contracts that capture all sources of compensation tied to pharmacy utilization
- Validate pricing, rebates, and financial guarantees
- Monitor clinical and financial performance on an ongoing basis, not just during renewal cycles
- Hold PBMs and other intermediaries accountable for acting in the best interests of the plan and its members

The takeaway is simple: transparency is not a safeguard – it is a tool. Its value depends entirely on how effectively employers use it to strengthen oversight, improve accountability, and drive better pharmacy benefit outcomes.

Where PBM Money Flows

A transparent contract starts with a funds-flow map (see example below), where employers require the PBM to disclose every source of direct and indirect compensation, including manufacturer rebates, administrative fees, price-protection amounts, data fees, affiliate revenue, specialty pharmacy economics, rebate-aggregator payments, network spreads, and recoupments from pharmacies.

This map allows employers to trace how much money moves through the PBM ecosystem, identify hidden or misaligned incentives, evaluate whether formulary and channel-management decisions are based on net plan value versus revenue optimization, and assess compliance with fiduciary obligations and contractual guarantees. Employers increasingly use this type of mapping as part of PBM procurement, audit, renewal, and fiduciary review processes because many compensation streams may exist outside traditional rebate disclosures or administrative fee reporting.

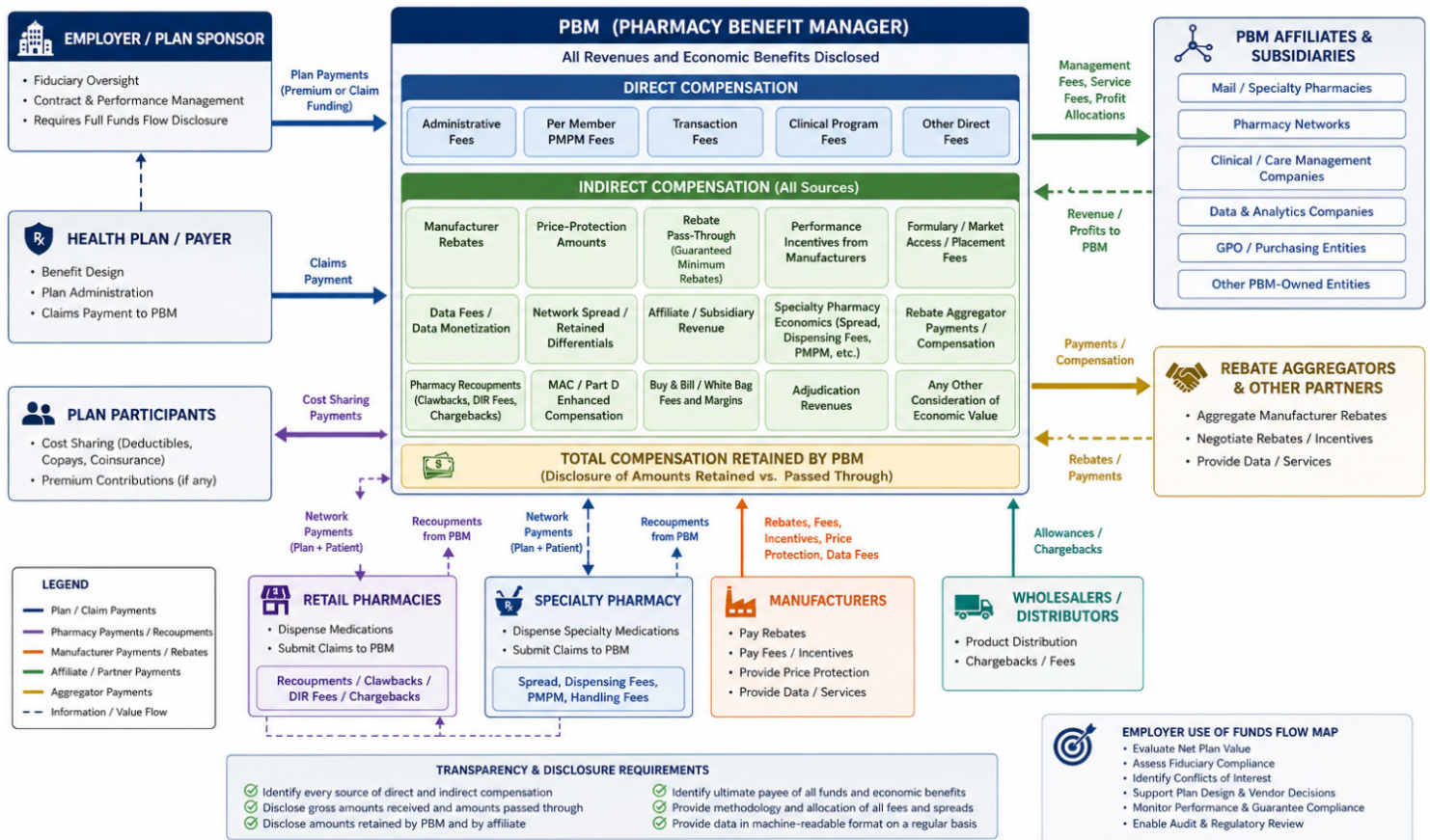
Employer Action Steps

- Direct the PBM to provide a compensation schedule that lists each payment category, who pays it, who receives it, and whether it is passed through, retained, or shared
- Specify in the contract how “rebate”, “discount”, “administrative fee”, “price protection”, “claw-back”, and “other compensation” are defined in the main agreement rather than a PBM-controlled exhibit
- Require full disclosure of any Percentage-of-Savings fees, including the formula used to calculate “savings”, the baseline reference price, and all underlying data sources, as these fees are a form of PBM remuneration and must be transparent to ensure incentives are aligned and savings are real
- Prohibit the PBM or any affiliate from retaining compensation not expressly disclosed and approved by the plan sponsor

Contracts that say “100% pass-through” without defining the full universe of compensation can still leave meaningful dollars outside the employer’s view.

EMPLOYER PBM FUNDS FLOW MAP

Full Disclosure of All Direct and Indirect Compensation

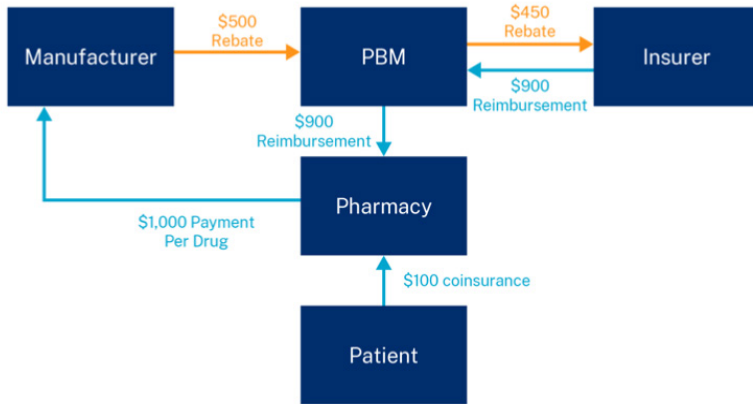


This funds-flow map is a conceptual illustration designed to help employers identify key financial flows, compensation arrangements, affiliate relationships, and areas requiring transparency, disclosure, and audit rights in PBM oversight. It was developed using publicly available regulatory findings, industry research, and analyses related to PBM contracting and prescription drug benefit management. Sources include FTC reports on prescription drug middlemen (2024–2025), Department of Labor transparency initiatives, CMS pharmacy reimbursement guidance, employer fiduciary standards, and PBM market transparency research.

The map does not represent any specific PBM contract, pricing model, or financial arrangement. Actual terms vary based on the employer, PBM, plan design, pharmacy network, and negotiated agreements. MBGH provides this map for educational and informational purposes only and assumes no responsibility for the accuracy, completeness, or use of this content. Employers should conduct their own due diligence and consult appropriate experts when evaluating PBM arrangements.



Figure 2: Flow of Payments and Rebates for a \$1,000 List Price Drug



Source: Paragon Health Institute [PBM 101](#)

What Price Transparency Really Means

True price transparency is broader than rebate pass-through. It includes claim-level visibility into ingredient cost, dispensing fees, benchmark methodology, channel economics (i.e., how money moves and margins are created), and whether the PBM is using spread pricing. FTC findings^{1,3} on specialty generics show why employers should also request net-cost reporting and channel-specific pricing transparency.

Employer Action Steps

Require all pricing exhibits and reimbursement schedules to clearly identify the benchmark methodology used, including each drug category, dispensing channel, and claim type, and whether reimbursement is based on primary drug-pricing benchmarks, such as:

- NADAC (National Average Drug Acquisition Cost)
- WAC (Wholesale Acquisition Cost)
- AWP (Average Wholesale Price)
- MAC (Maximum Allowable Cost)
- Other pricing benchmarks

Contracts should also specify how:

- Each benchmark is calculated, updated, adjusted, or replaced over time
- Who controls those changes, frequency of benchmark updates, any discretionary pricing authority retained by the PBM, and the employer's rights to review, audit, approve, or challenge benchmark modifications that materially affect plan costs or pharmacy reimbursement

Contract Clarity, Definitions & Audit Rights

A PBM contract is no longer just a pricing document – it is the primary tool employers use to govern pharmacy benefit performance and financial accountability. As PBM compensation and value increasingly flow through rebates, fees, affiliates, specialty pharmacies, and other indirect arrangements, vague contract language creates risk. Vague contract architecture does not just create ambiguity – it invites it. Employers cannot assume that disclosed terms reflect all sources of compensation and that contractual guarantees automatically produce the desired outcomes.

Strong contracts are built on clear definitions, transparency, and enforceability. Definitions should be broad enough to capture all forms of compensation and financial value, regardless of how they are labeled. Audit rights should function as an active oversight tool, allowing employers to verify pricing, rebates, fees, and performance across the entire pharmacy ecosystem, including affiliated entities and specialty pharmacies. Many arrangements fall short because:

- Employers receive information but lack the ability to independently validate it
- Audit rights are restricted by timing, sampling, or access limitations
- Key contract definitions are unclear or interpreted differently over time
- Corrective actions and repayment requirements are weak or difficult to enforce



Drug reimbursement isn't based on a single "price." PBMs choose from several pricing benchmarks — NADAC, WAC, AWP, MAC, or their own proprietary formulas, and each one produces a **different dollar amount** for the exact same drug. If the contract doesn't specify the benchmark and how it can change, the employer can't verify pricing, compare bids, or control total drug spend.



The result is often not intentional misconduct, but a gradual loss of value caused by unverified assumptions, incomplete reporting, and limited accountability.

Best practice is to design contracts with auditability in mind from the outset. Employers should have access to the data needed to independently validate performance, clear remedies when discrepancies are identified, and an ongoing governance process that monitors results throughout the contract term—not just during renewals or periodic audits.



Transparency without validation is not oversight. Employers must have the contractual ability to verify that reported performance matches financial and clinical reality.

Employer Action Steps

- Require annual and for-cause audit rights conducted by an independent auditor selected by the employer
- Ensure audit rights extend to all entities involved in delivering or administering pharmacy benefits, including specialty pharmacies, rebate aggregators, and affiliated organizations
- Require access to all records necessary to validate performance, including manufacturer payments, rebates, fees, formulary-related compensation, specialty pharmacy economics, and claims-level data
- Prohibit contract provisions that restrict audit effectiveness, such as limits on timing, sample size, audit location, or data access
- Include clear repayment obligations, corrective action requirements, and enforcement provisions when discrepancies or contract violations are identified
- Establish an ongoing governance process to regularly review pricing, utilization, rebates, guarantees, and financial performance throughout the contract term

Clinical Transparency & Evidence-based Formularies

Employers should insist that formulary decisions be explained in clinical and financial terms. FTC findings^{1,3} indicate that some rebate arrangements may limit access to lower-cost generics and biosimilars, while peer-reviewed literature highlights the need for structured biosimilar review, switching protocols, pharmacovigilance (ongoing safety monitoring of medicines and vaccines), and education. In practice, employers should be able to see who makes formulary decisions, which evidence is reviewed, and whether affiliate financial incentives influence preferred products or channels.

Employer Action Steps

- Require disclosure of formulary governance, committee structure, conflict policies, and advance notice of material formulary changes
- Require at least a 6-month evaluation period before:
 - Adding drugs that lack mature safety data, have unclear comparative effectiveness, or enter the market with high list prices and limited real-world evidence
 - Mandate ongoing monitoring during this period, including safety signals, utilization trends, and independent clinical reviews
 - Prohibit formulary placement during the review window unless new evidence emerges that meets employer-defined criteria
- Fast-track drugs with proven value by allowing expedited formulary placement for new drugs that demonstrate clear clinical benefit, strong safety data, and a well-understood cost profile at launch. Require transparent documentation from the PBM showing the evidence used to justify fast-tracking (e.g., breakthrough designation, strong comparative data, unmet need)
- Utilize best practices for adding a new drug to market, including establishing a formal intake and evaluation process for all FDA-approved new molecular entities
- Require a documented biosimilar review process covering clinical evidence, switching, education, and monitoring
- Preserve rights to request open formulary review or alternative sourcing when the PBM cannot demonstrate superior value
- Require the PBM to provide member-level transition support when formulary changes occur, including proactive outreach, clear instructions, and coordination with prescribers to prevent therapy disruption
- Ensure continuity-of-care protection for members who are stable on therapy, including exception processes and clinically appropriate grandfathering



The way our contract is structured, there is money to be found outside of discounts and rebates.

Fiduciary Alignment & Measurable Guarantees

For self-insured plans, transparency should support fiduciary decision-making. The CAA/ACA have raised the standard for employer oversight and now employers should oversee clinical appropriateness, benefit design, prior authorization (PA)/utilization management (UM) standards and member affordability as well as the contracts.

The U.S. DOL's² proposed disclosure rules are aimed at helping plan fiduciaries understand PBM compensation flows, identify conflicts, and assess reasonableness. Employers should build fiduciary alignment directly into the contract through conflict disclosures, measurable guarantees, corrective-action timelines, and meaningful penalties when the PBM's incentives diverge from the plan's best interests.

Employer Action Steps

- Use guarantees tied to claims accuracy, rebate remittance accuracy, data timeliness, formulary notice, specialty management, and audit cooperation
- Require disclosure of affiliate ownership and any financial incentives tied to steering members to PBM-owned pharmacies or higher-rebate products
- Include cure periods, financial penalties, and termination rights for inaccurate reporting, undisclosed compensation, or repeated conflict-of-interest breaches



Preserving Employer Control & Specialty Flexibility



A transparent PBM model still fails if the employer cannot shape the benefit.

Doing nothing is an active cost decision.

Transparency is only valuable if employers have the ability to act on what they see. A pharmacy benefit is shaped by decisions about formularies, utilization management, specialty pharmacy, biosimilars, and member cost sharing. When those decisions are controlled entirely by the PBM, employers lose the ability to direct strategy and manage costs effectively.

In today's specialty-driven environment, doing nothing is a decision. Drug selection, utilization patterns, and specialty pharmacy management have a major impact on costs. Without employer oversight, unnecessary spending can become embedded in the benefit and grow over time. Maintaining flexibility is especially important in specialty pharmacy, where costs are highest and financial incentives are often the most complex. Employers should retain the ability to evaluate and implement alternative approaches, such as specialty carve-outs, independent rebate programs, biosimilar strategies, or direct contracting arrangements when they offer better value.

Access to data is equally important. Getting and understanding data and trend is the first meaningful step toward control. Employers need complete, claims-level data—including visibility into medical benefit drugs—to understand spending, identify trends, and make informed decisions. They should also be able to change vendors or strategies without losing access to historical data or disrupting operations.

Employer Action Steps

- Retain approval rights over key benefit decisions, including formulary changes, specialty pharmacy strategy, utilization management programs, biosimilar adoption, and member cost sharing
- Preserve the ability to implement alternative approaches, such as specialty carve-outs, independent rebate arrangements, or other strategies for managing high-cost drugs
- Require full access to claims-level data, including J-code reporting for medical benefit drugs
- Ensure data portability, transition support, and access to historical data so the plan can change vendors or strategies when needed

Transparency provides information. Control, flexibility, and access to data allow employers to use that information to improve performance and manage costs.



Getting and understanding your data and trend is the first meaningful step into empowerment.

Expanding Role of Alternative/Transparent PBMs

Often marketed as an employer-aligned or a fiduciary-oriented alternative to traditional vertically integrated PBM models owned by large insurers or healthcare conglomerates, an Alternative/Transparent PBM is a model designed to reduce financial conflicts of interest and provide employers with greater visibility into how prescription drug costs, rebates, fees, and pharmacy reimbursements are managed.

Since the term “transparent” does not necessarily mean lower cost, conflict-free, or fully aligned with employer interests, for purposes of this Employer Action Brief, we will use the term Alternative PBM.

Unlike traditional PBM arrangements, which often rely on spread pricing, retained rebates, administrative fees, specialty pharmacy margins, and other indirect revenue streams, Alternative PBMs typically position themselves around pass-through pricing, disclosed compensation, and employer access to claims and financial data.

Common characteristics may include:

- Pass-through pricing – the employer pays the same amount the PBM reimburses the pharmacy
- Full or substantially disclosed rebate arrangements
- Administrative fees that are fixed and clearly defined
- Reduced reliance on spread pricing or retained rebate revenue
- Greater employer access to claims-level data and audit rights
- More transparent formulary and specialty pharmacy arrangements
- Independent clinical and utilization management models intended to reduce conflicts of interest

While transparency is valuable and can improve visibility into pricing and compensation structures, it is not sufficient on its own. Even with an Alternative PBM model, employers should still evaluate:

- Total net cost
- Contract definitions and exclusions
- Specialty drug management practices
- Manufacturer rebate arrangements
- Data access limitations
- Clinical management incentives
- Audit enforceability
- Overall alignment between PBM compensation and employer objectives

In practice, an Alternative PBM is best understood not as a guarantee of savings, but as a different contracting and disclosure model that may provide employers with greater oversight, negotiating leverage, and operational visibility compared to traditional PBM arrangements.

Role of Pharmacy Benefits Consultants

The primary role of a pharmacy benefits consultant is to serve as the employer’s independent advisor and advocate. Their responsibility is to help ensure that the pharmacy benefit program delivers the best combination of affordability, access, quality, and value while holding the PBM accountable for performance.

Effective consultants combine financial, contractual, and clinical expertise. They analyze data, identify opportunities for improvement, evaluate PBM programs, and recommend strategies that improve outcomes while controlling costs. They also provide employers with access to a broader range of pharmacy benefit models and solutions rather than relying solely on standard PBM approaches.

Key Responsibilities of a Pharmacy Benefits Consultant:

- PBM Contract Negotiation and Oversight – Negotiate transparent, enforceable contracts and monitor performance against contractual commitments
- Financial Stewardship – Evaluate PBM compensation, pricing arrangements, rebates, and other financial flows to ensure value is delivered to the plan
- Clinical and Formulary Strategy – Assess formularies, utilization management programs, biosimilar opportunities, and specialty pharmacy strategies to improve outcomes and manage costs
- Data Analytics and Performance Monitoring – Analyze claims and financial data, identify trends, validate results, and recommend corrective actions when needed
- Benefit Design and Strategy – Help employers develop pharmacy benefit strategies that align with their workforce needs, objectives, and risk tolerance
- Transparency and Audit Support – Assist with audits, financial validation, reporting, and governance processes to ensure accountability across all pharmacy benefit stakeholders

The best pharmacy benefits consultants do more than negotiate contracts. They help employers actively manage pharmacy benefits as an ongoing clinical and financial program, ensuring that decisions, performance, and outcomes remain aligned with employer goals.



We use our consultant as a sounding board for ideas and questions and to better understand if they will be helpful in conversations with our PBM. We have flexibility with our PBM, but we all need to tap into individuals who have expertise more often.

We are leaning on our consultant, and it has given us leverage on things we can push back on. It hasn't been anything huge like administrative fees, but more on operations and how their customer services systems operate.

Recommendations for Alternative PBM Contract Language

Use this matrix to compare common or missing contract language against a stronger transparency standard. Illustrative language should be reviewed by legal counsel.

Topic	Common weak or missing language	Preferred transparency language
Compensation	PBM may retain customary market compensation.	PBM will disclose, itemize, and define all direct and indirect compensation — including all payments, credits, fees, price-protection amounts, data monetization, affiliate revenue, spread amounts, and any other remuneration — by source, service, and recipient. No compensation, in any form, may be retained, earned, or received by the PBM or its affiliates unless it is expressly identified in this agreement. All compensation categories and definitions must appear in the main agreement and be subject to employer audit and verification.
Rebates	100% of rebates passed through.	“Rebates” and “other remuneration” will be defined broadly in the main agreement to include all manufacturer, aggregator, data-monetization, price-protection, administrative, inflation-penalty, and market-share payments, credits, or offsets, regardless of label or channel. All such remuneration must be fully disclosed, itemized, and passed through to the Plan unless explicitly excluded in this agreement. No category of manufacturer or third-party compensation may be retained, reclassified, or netted by the PBM or its affiliates. All rebate and remuneration categories are subject to employer audit and verification.
Spread pricing	Silent on spread across channels.	The Plan will pay only the actual pharmacy reimbursement amount (ingredient cost plus dispensing fee) and the separately disclosed administrative fee. All spread pricing — including retail, specialty, mail, and affiliate-owned channels — is prohibited unless the Employer expressly elects it in writing. PBM must disclose the reimbursement amount paid to each pharmacy and certify that no additional margin, markup, or differential was retained. All reimbursement and fee data are subject to employer audit.
Reporting	Aggregate savings reports only.	PBM will provide claim-level and drug-level reporting for all adjudicated claims, including gross cost, ingredient cost, dispensing fee, rebates and all other remuneration, net cost, utilization, fulfillment channel, and specialty-pharmacy economics. All reporting must be delivered in a machine-readable format and include sufficient detail to allow the Employer to verify pricing, guarantees, and contract compliance. No reporting categories may be withheld, aggregated, or reclassified without Employer approval.
Audit rights	Audit allowed under PBM rules.	Employer may conduct annual and for-cause audits using an auditor of their choosing. PBM will provide timely access to all data, records, contracts, pricing files, manufacturer agreements, rebate and remuneration inventories, specialty-pharmacy economics, and any other information reasonably necessary to verify compliance. PBM may not restrict audit scope, sample size, location, or methodology. All audit findings must be remediated within a defined cure period, and any financial reconciliation amounts must be paid to the Employer.

Formulary governance	PBM may change formulary at its discretion.	PBM will disclose its formulary governance process, including evidence standards, clinical review criteria, conflict-of-interest safeguards, and the role of financial arrangements in placement decisions. PBM must provide advance written notice of all material formulary changes, including additions, removals, tier changes, step-therapy requirements, and prior-authorization modifications, with sufficient detail for the Employer to assess member impact and cost implications. No formulary change may be implemented without the required notice. All governance materials and change logs are subject to the Employer audit.
Biosimilars	No language.	PBM will maintain an evidence-based biosimilar strategy that includes clinical review, formulary placement, switching protocols, member and provider education, monitoring of outcomes, and exceptions processes. PBM must disclose all biosimilar evaluation criteria, including comparative evidence, safety data, interchangeability status, and financial arrangements. Any switching program must include proactive member outreach, prescriber coordination, and monitoring for discontinuation or adverse outcomes. All biosimilar decisions and transition results are subject to the Employer review and audit.
Affiliated pharmacies	Use PBM specialty pharmacy when clinically appropriate.	PBM will disclose all affiliate and subsidiary ownership interests, including specialty, mail, infusion, and hub-service entities. PBM must provide comparative pricing, service levels, dispensing accuracy, turnaround times, and channel economics for affiliate and non-affiliate pharmacies. PBM may not steer members to an affiliate pharmacy through differential pricing, network design, or benefit restrictions unless expressly approved by the Employer. All affiliate performance and economics are subject to audit by the Employer.
Guarantees	General service guarantees with offset rights.	PBM guarantees will cover claims accuracy, pricing accuracy, rebate and remuneration accuracy, data timeliness, formulary and clinical-program notice, specialty-pharmacy performance, and audit cooperation. PBM may not offset guarantee shortfalls against other guarantees or financial obligations unless expressly approved in writing by the Employer. All guarantees must be measurable, independently verifiable, and reconciled annually with full financial transparency.
Exit rights	Standard termination only.	The Employer may terminate the agreement without cause with 90 days' notice. Upon termination, PBM will provide full transition support, including data portability, member communications, formulary and UM files, rebate and remuneration inventories, and run-out claims processing. PBM must supply all data in machine-readable format and cooperate fully with the Employer and any successor vendor to ensure a seamless transition for members. No fees may be charged for data access or portability unless expressly stated in this agreement.

Choosing an Alternative PBM is Not Enough!

In search of greater transparency, flexibility, and alignment, more employers are exploring alternatives to the Big Three PBMs. This shift is being driven by practical concerns about rising drug costs and a growing recognition that size alone does not guarantee better performance.

In some cases, Alternative and mid-market PBMs have delivered stronger results than larger competitors. They may offer more transparent

pricing, faster adoption of biosimilars, greater flexibility in specialty pharmacy management, and business models that are easier for employers to understand and oversee. When combined with strong employer oversight, these approaches can help improve outcomes and reduce costs.

However, choosing a different PBM is not a solution by itself. Pharmacy costs are driven by

drug utilization, clinical management, formulary decisions, specialty pharmacy strategies, and member behavior. Regardless of which PBM is selected, employers must continue to actively monitor performance, manage utilization, and hold vendors accountable. In other words, changing platforms without upgrading governance simply relocates the problem rather than resolving it.

The key question is not whether a PBM is large or small, it is whether the PBM’s business model, clinical programs, pricing approach, and incentives align with the employer’s goals.

Employers should also work with independent advisors who understand a wide range of PBM models and can objectively evaluate alternatives. Selecting a PBM should be based on performance,



transparency, flexibility, and alignment—not brand recognition or market share.

A different PBM does not automatically deliver better results. Alternative and mid-market PBMs can offer meaningful advantages, but success depends on strong contracts, active oversight, sound clinical management, and ongoing performance validation. The PBM matters, but employer governance and accountability matter more.

General Contract Guidance

Employer Action Steps

Use the following steps to ensure your PBM contract is strong and fiduciary focused.

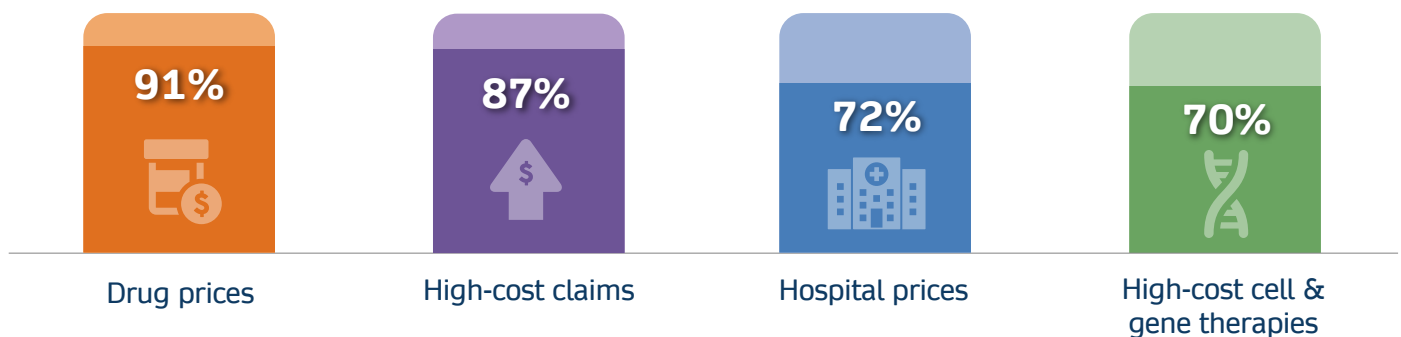
- Run a clause-by-clause review of the current PBM agreement against the matrix above
- Request drug-level net-cost and biosimilar reporting for the top specialty and rebate-driven categories
- Expand the audit clause so it covers rebates, spread pricing, formulary rationale, and specialty economics
- Align benefits, finance, procurement, and legal stakeholders on the plan’s fiduciary expectations before negotiating

Employer Insights

Pulse of the Purchaser Employer Survey

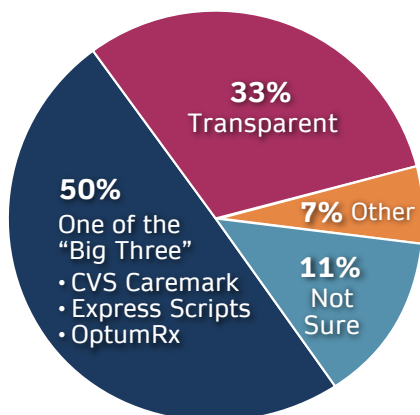
This annual MBGH employer survey is held in conjunction with the National Alliance of Healthcare Purchaser Coalitions and its member coalitions. Conducted in 2025, the charts below represents MBGH employer member responses.

Perspectives on Significant Threats to Affordability



Pharmacy Benefits Priorities and Strategies

Employers' Primary PBM Contracts are with:



Since last year's survey, **21%** of employers indicate they made a PBM change. Another **48%** are considering a change in the next 1-3 years. Employers are looking to achieve:

- Better pricing
- More transparency
- Formulary control
- Fiduciary duty compliance

"We are actively researching and analyzing non-Big 3 options."

PBM Strategies Employers are Currently Utilizing



Promotion and inclusion of biosimilars on formulary (22% considering)



Full and independent audit rights of PBM contracts and rebate agreements (27% considering)



Confirmation that advisors do not receive any direct or indirect compensation from PBMs or related third-parties (25% considering)



Ownership of all data generated by the health plan (22% considering)

PBM strategies being considered: complete transparency regarding net/ingredient cost by drug inclusion of cell & gene therapies and full disclosure of all revenue streams with affiliated pharmacy-related entities.

Are Rebate-Free PBMs Really Free?

The "Rebate-Free" PBMs may not be what they present themselves to be. They may simply have reclassified their rebates into other opaque fees, spread pricing, data and/or service fees, or administrative charges. These PBMs are simply reducing visibility into rebates or price adjustments. Employers need to require transparency into all manufacturer agreements and arrangements and maintain their skepticism.

Additional supporting statements shared how "rebate-free" models may still preserve hidden revenue streams, and included:

- Rebate dollars do not simply disappear. They get reclassified into administrative fees, data fees, spread pricing, or service fees.
- True PBM transparency requires clear line-of-sight into acquisition cost, dispensing fees, administrative fees, and any retained revenue, not just a shift in how rebates are labeled.

FTC and policy scrutiny around rebate structures and alternative PBM revenue models continues to focus on whether incentives and pricing opacity actually change.

PBM Evaluation & Contracting Due Diligence Questions

As PBM transparency requirements increase, employers should use the renewal process to evaluate not only pricing guarantees, but also alignment, disclosure, auditability, and fiduciary accountability. Increasing transparency requirements creates an opportunity for employers to evaluate whether PBM arrangements are financially aligned, clinically appropriate, operationally auditable, and structured to support long-term plan sustainability.

Use these questions to guide your PBM renewal as they should no longer be treated as routine procurement exercises.

Compensation Transparency & Financial Flows

- What compensation streams are retained anywhere in the PBM organization, including affiliates, subsidiaries, and aggregators?
- What sources of compensation exist beyond administrative fees (e.g., rebates, discounts, incentives, service fees, spread pricing, or other remuneration)?
- Are all rebates, fees, discounts, and other compensation fully disclosed and contractually defined?
- Does the PBM retain any portion of manufacturer rebates or administrative fees? (If this question is not strong enough, consider one of the following)
 1. Describe all direct and indirect compensation retained by the PBM, its subsidiaries, affiliates, rebate aggregators, group purchasing organizations (GPOs), specialty pharmacies, or related entities arising from the employer's pharmacy benefit, including but not limited to manufacturer rebates, administrative fees, formulary placement payments, price-protection amounts, market-share incentives, data fees, bona fide service fees, and any retained spread or margin. Specify what percentage or dollar amount is retained versus passed through to the employer.
 2. Provide a complete accounting of all revenue, compensation, credits, incentives, remuneration, or financial consideration received directly or indirectly by the PBM or any affiliated entity in connection with the employer's prescription drug program. Identify the source, calculation methodology, timing, retention amount, and pass-through amount for each compensation stream, including all manufacturer rebates, administrative fees, GPO payments, specialty pharmacy economics, data monetization revenue, network spreads, and performance guarantees.
- Is the contract structured as fully pass-through, partially pass-through, or spread-based?
- How is spread pricing measured, disclosed, and reconciled?
- What indirect compensation arrangements exist with manufacturers, pharmacies, or group purchasing organizations (GPOs)?

Formulary Design & Rebate Strategy

- How are formulary placement decisions made, and what criteria determine preferred products?
- To what extent are formulary decisions influenced by rebate optimization versus net clinical and cost value?
- What percentage of rebates and manufacturer incentives are passed through to the employer?
- Are rebate guarantees tied to formulary exclusions, utilization controls, or performance thresholds?
- How are biosimilars and lower-net-cost alternatives evaluated and positioned?

Data Access, Transparency & Audit Rights

- What level of claims data access is provided (claim, drug, class, channel level), and how frequently is it available?
- Can the employer independently audit rebates, pharmacy reimbursements, and specialty drug claims?
- Are audit rights contractually enforceable, operationally feasible, and free of material restrictions?
- How often can audits occur, and what limitations exist on scope, methodology, or recoveries?
- What reporting transparency is available for formulary decisions and utilization management?



We have our data, yet it is complex, and we have no place to store and scrub it. You absolutely need someone to assist you who knows more than you, especially in the PBM space because it is moving so fast.

We obtain data from our carrier so we can validate it. We will have an independent party review our upcoming contract and although we are not expecting much more of an independent party review, we are using counsel that specializes in PBM contracts.

Employers must have actionable data so they can take action. Often when they dig into their contracts, they may learn that it's just an executive summary and that they are making decisions based off that. We need the power to have access to our own data, and not be charged an arm and a leg to obtain it.

Specialty Pharmacy & High-Cost Therapies

- Is utilization being steered to affiliated specialty pharmacies or related entities?
- How are specialty drug pricing structures defined (markups, dispensing fees, service fees, and reimbursement models)?
- What oversight applies to gene therapies, cell therapies, and other high-cost treatments?
- Are site-of-care optimization and prior authorization programs evidence-based and independently validated?
- What alternative funding structures or accumulator/maximizer programs are in place?

Clinical Management & Member Impact

- How are prior authorization and step therapy protocols developed and reviewed?
- Are clinical programs independently evaluated for evidence, outcomes, and appropriateness?
- What metrics are used to assess member disruption, abandonment, adherence, and continuity of care?
- How are appeals and exceptions handled operationally?
- Does the PBM evaluate total cost of care or primarily focus on pharmacy spend reduction?



Contract Structure, Governance & Fiduciary Alignment

- Does the contract clearly define all compensation streams and affiliated entities?
- What performance guarantees exist and are they aligned with employer objectives and member outcomes?
- What termination rights exist if transparency, pricing, or performance obligations are not met?
- How are conflicts of interest disclosed, governed, and mitigated?
- Does the PBM acknowledge fiduciary standards or accountability expectations in its role?
- How will the PBM support data portability, transition, and continuity of member service if a change in model occurs?

Oversight, Transparency Definitions & Strategic Risk

- How does the PBM define transparency in practice?
- What revenue streams remain outside standard disclosure or reporting frameworks?
- What assumptions underpin projected savings guarantees and pricing commitments?
- How does the PBM adapt its revenue model when rebate, spread pricing, or regulatory structures change?
- What independent validation supports claimed savings, performance metrics, and clinical outcomes?
- What proof demonstrates that formulary and specialty channel decisions are based on net value and clinical efficacy rather than rebate yield?

What's Next?

In today's increasingly complex pharmacy benefits landscape, employers that understand how PBMs generate revenue, structure contracts, manage formularies, and align incentives are better positioned to make informed decisions and achieve stronger outcomes. By applying the principles outlined in this action brief, employers can strengthen oversight of their pharmacy benefits program and negotiate more effective and accountable contracts. Ultimately, a well-informed and proactive approach enables employers to align pharmacy benefit strategies with the needs of their organizations and members. This alignment creates a three-fold benefit which drives greater value, improves health outcomes, and sustains costs in the long-term.

About MBGH

Midwest Business Group on Health (MBGH) is a 501c3 non-profit supporting employers seeking solutions to better manage the high cost of health care and the health and productivity of their covered populations.

Founded in 1980, MBGH offers members leading educational programs, employer-directed research projects, purchasing opportunities and community-based activities that increase the value of health care services and the health benefits they offer to members. MBGH serves over 180 companies who provide benefits to over 4 million lives, with employer members spending more than \$15 billion on health care each year.

mbgh.org

Authors



Cheryl Larson
President & CEO
MBGH



John Butler
Project Consultant
MBGH



Erin Pataky
Director of Member Initiatives
MBGH

The information provided in this resource is based on the author's and contributors' experiences working in the health benefits and health care industry. For more information on any aspect of this report, please contact info@mbgh.org.

References

1. Federal Trade Commission: [Interim Staff Report on Prescription Drug Middlemen](#), 2024
2. U.S. Department of Labor: [Fact Sheet: Proposed Pharmacy Benefit Manager Fee Disclosure Rule](#), 2026
3. Federal Trade Commission: [Second Interim Staff Report on Prescription Drug Middlemen](#), 2025
4. U.S. Department of Labor. (2026, January). [Fact Sheet: Proposed Pharmacy Benefit Manager Fee Disclosure Rule](#).

Resources

1. Health Affairs Scholar: [The cost of misaligned incentives in the pharmaceutical supply chain](#), 2025
2. National Alliance of Healthcare Purchaser Coalitions: [Celebrates Passage of Bipartisan Healthcare Reform, Delivering Landmark PBM Transparency for Employers](#), 2026
3. National Alliance of Healthcare Purchaser Coalitions: [Survey Finds Employers with Access to Claims Data Likelier to Adopt Higher Value Strategies that Reduce Costs](#), 2025
4. National Library of Congress: [An Institutional Guide for Formulary Decisions of Biosimilars](#)
5. National Alliance of Healthcare Purchaser Coalitions: [PBM Misalignment Initiative FINAL REPORT](#), 2025