



PBM Misalignment Initiative

FINAL REPORT



National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

Table of Contents

Executive Summary	1
Current PBM Landscape	3
Addressing Employers' Financial Concerns	5
The Issue of Non-Transparent Pricing Models	5
Actionable Steps for Employers	6
Taking Control With Health Plan Audits	7
Actionable Steps for Employers	7
Conclusion	9
Addendum	10
About the Employer Workshops	10
High-Level Employer Concerns	10
National Alliance Resources	11



Executive Summary

The National Alliance developed the PBM Misalignment Initiative to investigate and address misalignment between employers and their pharmacy benefit management (PBM) service providers.

Building on the 2023 [PBM playbook](#), created for employers conducting a service provider search or renegotiating contracts, this initiative further explores the factors driving PBM misalignment and identifies opportunities for employers to improve their management of pharmacy benefit programs.

This final report outlines the initiative’s scope, its key takeaways, and its deliverables. It also provides an overview of the current PBM landscape, examines the factors driving PBM misalignment, and identifies actionable steps employers can take to improve alignment with their PBM service providers.”

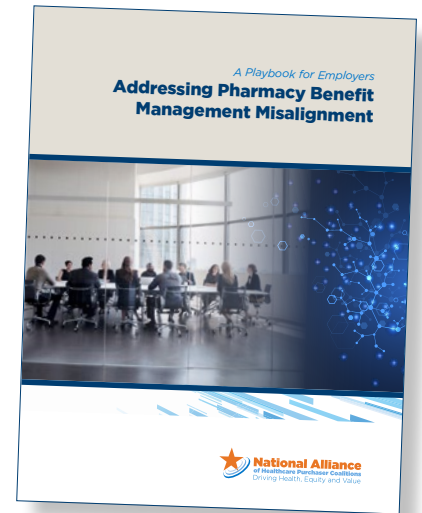
Key Takeaways

- ▶ The National Alliance PBM Initiative advances the action steps set forth in the 2023 [PBM playbook](#) to help employers and other plan sponsors understand and address misalignment of PBM business practices that negatively affect employees and benefits management.
- ▶ The PBM landscape is ripe for change due to the increasing urgency among employers to hold PBMs accountable to price transparency and CAA compliance.

“There’s a broadening gap between employers’ goals for their pharmacy benefit program and what they’re getting from their PBMs.”

—CHRISTINA BELL,
SENIOR DIRECTOR OF HEALTHCARE
ADVANCEMENT, NATIONAL ALLIANCE OF
HEALTHCARE PURCHASER COALITIONS

- ▶ By working together, employers can drive transformation across the PBM supply chain.
- ▶ Employers now have a [library of National Alliance Resources](#) to guide and empower them on their journey to achieving PBM transparency and fair pricing.
- ▶ National Alliance coalitions and their employer members play a pivotal role in applying sustained pressure and influencing policy change about expectations for the PBM industry.



Project Scope


This project used a comprehensive strategy to engage employers and identify real-world challenges they face in complying with the CAA and other legislative requirements. The strategy involved developing employer-focused resources, including case studies, infographics, and a vendor engagement template, and hosting two employer workshops that highlighted effective practices for driving change in pharmacy benefit plans.

The employer coalitions selected for the workshops were [Pittsburgh Business Group on Health](#) and the [Washington Healthcare Alliance](#). The workshops were attended by their employer members with relevant experience in effectively driving change in pharmacy benefit plans. (More information on project deliverables can be found on page 2.)

National Alliance PBM Misalignment Initiative Deliverables

(Click on the images to view)

Regional Workshops



Objective: Gain a deeper understanding of the current state of pharmacy benefits, how PBMs operate in ways that are out of alignment with employer needs and requirements, and promising interventional tactics.

PBM Vendor Engagement Template



Objective: Equip purchasers with information to assist in evaluating and comparing PBM proposals.



Employer Case Studies




Objective: Showcase actionable steps employers are taking, from implementing strategies to disrupt components of their PBM programs to exploring alternative PBM vendors.

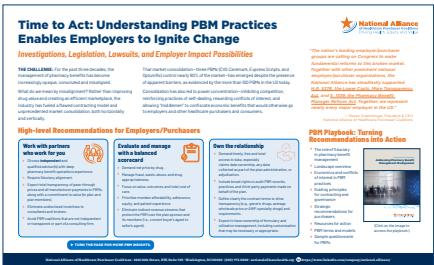


- Coalition PBM Case Study: Employers' Advanced Cooperative on Healthcare/Employers ChoiceRx** - Helping the State Gain Results of Traditional PBM
- Coalition PBM Case Study: Making Pharmacy Benefits Work for Plan Sponsors and Members**
- Employer PBM Case Study: State of Tennessee Saves Millions by Removing Wasteful Drugs**
- Employer PBM Case Study: Nelman Enterprises Lowers Wasteful Pharmacy Spend by 75.5%**
- Employer PBM Case Study: How and Why a Manufacturing Company Selected a New PBM**

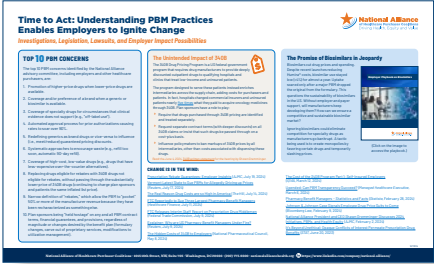
Infographics



Placemat One Objective: Educate employers about the PBM landscape and identify opportunities for action.



Placemat Two Objective: Identify how employers can leverage brokers and consultants as *their* agents, not “partners” to the PBM.



Current PBM Landscape

The relationship between employers and pharmacy benefit management (PBM) service providers is under increasing scrutiny due to concerns about misaligned incentives, opaque pricing, and evolving regulatory requirements. Employers are seeking strategies to ensure their health plans, particularly prescription drug benefits, are designed and managed in the best interest of employees, balancing cost, transparency, and access to care.

A core issue with the PBM model lies in its inclusion of perverse financial incentives, which enable PBMs to maximize profits while obscuring the true cost of medications. PBMs negotiate significant rebates with manufacturers, but the extent to which these rebates are passed back to employers/plan sponsors or employees remains unclear. This opacity has raised concerns over whether PBM practices are driving up drug prices, ultimately shifting costs onto plan sponsors and beneficiaries.

In recent years, legislative efforts such as price transparency regulations and the Consolidated Appropriations Act (CAA) have pushed for greater accountability. The CAA requires employers to conduct a more thorough review of their PBM contracts and prescription drug pricing data to ensure compliance with transparency standards. As a result, employers are faced with greater complexity in ensuring PBM arrangements comply with regulatory requirements while maintaining affordability and access.

Employers operating under the Employee Retirement Income Security Act (ERISA) face additional fiduciary duties to manage plan assets, including health benefits, in a manner that prioritizes the wellbeing of their employees. This fiduciary duty includes scrutinizing PBM contracts to ensure they are structured to benefit employees rather than intermediaries. ERISA's fiduciary requirements around health plans have become a focal point for employers, who must

Understanding the PBM Landscape

Key elements shaping the landscape:

- ▶ **PBM consolidation:**
~80% of the market is controlled by 3 PBMs, 6 companies control 96% of the PBM market
- ▶ **Vertical integration:**
Large PBMs are integrated with insurance companies, healthcare providers, and pharmacies
- ▶ **PBM Misalignment:**
Many PBM practices are misaligned with employer benefits goals

Parent/Owner	CVS Health Corporation	The Cigna Group	UnitedHealth Group Inc.	Humana Inc.	MedImpact Holdings Inc.	19 BlueCross BlueShield plans
Drug Private Labeler	Cordavis Limited	Quallent Pharmaceuticals	NUVAILA			
Health Care Provider	MinuteClinic, Signify Health	Evernorth Care Group	Optum Health	CenterWell		
Pharmacy Benefit Manager	34%	23%	22%	7%	5%	3%
"PBM GPO"/ Rebate Aggregator	Zinc Health Services	Ascent Health Services	Emisar Pharma Services	Ascent (via contract)	Prescient Holdings Group LLC	Ascent (minority owner)
Pharmacy - Retail	CVS Pharmacy					
Pharmacy - Mail Order	CVS Caremark Mail Service Pharmacy	Express Scripts Pharmacy	Optum Rx Mail Service Pharmacy	CenterWell Pharmacy	Birdi, Inc.	Express Scripts Pharmacy (via contract)
Pharmacy - Specialty	CVS Specialty Pharmacy	Accredo	Optum Specialty Pharmacy	CenterWell Specialty Pharmacy	Specialty by Birdi	Accredo (via contract)
Health Insurer	Aetna	Cigna Healthcare	UnitedHealthcare	Humana		19 BlueCross BlueShield plans

Image source: Federal Trade Commission. FTC releases interim staff report on prescription drugs middleman. <https://www.ftc.gov/news-events/news/press-releases/2024/07/ftc-releases-interim-staff-report-prescription-drug-middlemen>

now navigate an increasingly complex regulatory environment while managing plan assets prudently.

For non-ERISA employers, state laws impose similar obligations under the “duty of prudence,” requiring them to act in the best interest of employees when managing healthcare benefits. [A Commonwealth Fund review](#) suggests that state-level regulations are evolving to mirror federal transparency mandates, further complicating the landscape for employers as they seek to effectively manage PBM contracts.

With these pressures, employers are increasingly turning to data-driven strategies and real-world case studies to improve the alignment of their PBM agreements. There is a need for actionable approaches to align PBM contracts with employer goals. Employers

are now pursuing more aggressive contract terms, including transparency clauses, performance guarantees, and pass-through pricing models, to ensure that savings generated by PBMs are fully realized by plan sponsors and beneficiaries.

The shifting PBM landscape presents challenges and opportunities for employers. Through careful contract reviews, enhanced oversight, and the implementation of best practices, employers can better align PBM arrangements to ensure cost-effective, transparent, and employee-centered health benefits. The latest research and data point to the need for greater diligence, accountability, and innovative strategies to meet the evolving demands of managing prescription drug benefits in today’s environment.



Addressing Employers' Financial Concerns

Enhancing PBM Transparency and Accountability

As drug prices continue to rise and the healthcare landscape shifts, employers are increasingly focused on addressing the financial impact of PBM practices. The growing scrutiny of drug pricing—coupled with recent legislative efforts and litigation—makes this a top priority for employers seeking to prioritize transparency and protect their financial interests and those of employees.

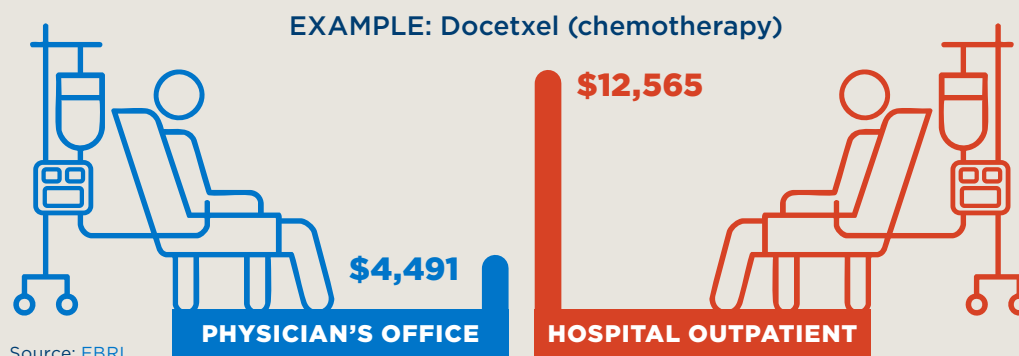
The Issue of Non-Transparent Pricing Models

One of the most pressing concerns for employers is how PBM contract terms can obscure drug pricing. Many PBMs use complex pricing structures, often driven by rebates and financial incentives from pharmaceutical manufacturers. This makes it difficult for employers

to gauge the true cost of prescription drugs. The PBM Misalignment Initiative collected [real-world patient case studies](#) shared by employers and coalitions where inconsistent pricing for high-cost medications across different care settings raised questions about PBM pricing practices and highlighted the financial burden placed on employees and their families, who faced significant out-of-pocket costs.

A growing area of concern has been the 340B drug pricing program, which, while intended to reduce drug costs for certain healthcare providers, may unintentionally contribute to pricing inequities and legal concerns for employers. These concerns make it essential for employers/plan sponsors to take a closer look at PBM contracts and pricing structures.

Hospital prices for the top 37 infused cancer drugs averaged 86.2 percent more per unit than in physician offices



Top Takeaways

1. Costs for physician-administered drugs are far more expensive in hospitals vs. physician offices.
2. Hospitals are retaining a greater share of insurer spending.
3. Employers are paying far more for the same drug at different sites of care.

Percentage of Insurer Spending on Infused Drugs that is Retained by Hospitals and Physician Practices

Drug Type	Hospitals Eligible for 340B Discounts	Hospitals Not Eligible for 340B Discounts	Independent Physician Practices
All Drugs	64.3%	44.8%	19.1%
Drugs for oncologic patients	64.6%	50.0%	17.3%
Drugs for inflammatory conditions	68.0%	55.2%	19.0%
Drugs for blood-cell deficiency disorders	55.8%	9.1%	29.8%

Source: [The New England Journal of Medicine](#)

Actionable Steps for Employers

➔ Prioritize Contract Transparency

To address these issues, employers must hold PBMs accountable by demanding transparent contracts. A critical step is to ensure PBM contracts include explicit language that enforces price transparency and compliance with the CAA. Employers can insist on an independent standard of duty for PBMs and require brokers and consultants to disclose any potential conflicts of interest, whether direct or indirect. Transparency from all parties is key to ensuring that PBMs act in the best interest of employers and their employees.

“The primary customers of PBMs—employers and purchasers—are rightly concerned about self-dealing, conflicts of interest, and the confiscation of economic benefits that would otherwise go to the organization, its employees, and families.”

—SHAWN GREMMINGER
PRESIDENT AND CEO, NATIONAL ALLIANCE OF
HEALTHCARE PURCHASER COALITIONS

If employers or plan sponsors work with brokers or consultants to manage their PBM relationships, it is advisable to request full disclosure of any commissions, incentives, or compensation these service providers receive from PBMs. Some employers have found it beneficial to require an independent evaluation of purchasing collaboratives, as these arrangements can also pose potential conflicts of interest.

When conducting a PBM search or renegotiating contracts, employers/plan sponsors should **insist that proposals and requests for proposals (RFPs) include the lowest net cost and unit prices for the top 500 drugs (view the [National Alliance PBM Vendor Engagement Template](#))**. Rather than accepting percentage-based discounts, employers/plan

sponsors should demand full disclosure of all forms of compensation, including rebates and incentives from third-party entities. This approach ensures they pay the actual value without hidden fees or incentives that inflate costs.

➔ Review the Plan Formulary: Take Control of Drug Utilization

A key element of addressing financial concerns is the management of the plan formulary. PBMs often drive drug utilization toward higher-cost medications through reliance on rebates that benefit the PBM but not the employer or employee. To combat this, employers/plan sponsors are advised to require PBMs to implement an independent pharmacy & therapeutics (P&T) committee or, if possible, carve out this service, with full disclosure of committee members. An independent P&T committee can ensure that drug formularies are based on clinical effectiveness and cost efficiency, rather than PBM profit motives.

Additionally, employers may want to explore the creation of custom formularies, which provide greater control **over drug selection** and cost management, while maintaining access for clinically appropriate care. Using this method, employers can require PBMs to disclose the entire drug formulary, including the anticipated unit price for each medication. In cases where PBMs charge for custom formulary services, employers must push back and reject these surcharges, which add unnecessary costs to the overall health plan.

➔ Take Action for Greater Transparency and Accountability

As employers navigate PBM relationships, the emphasis **must be on transparency and accountability**. By implementing these actionable strategies—demanding contract transparency, ensuring independent evaluations, and taking control of the formulary—costs can be significantly reduced and overall value improved. In an era of increasing regulation and financial pressure, taking these steps will not only enhance compliance but also protect the financial health of employers and employees.

Taking Control with Health Plan Audits

Complying with Performance Standards and the CAA



A key regulatory focus for employers is the CAA, which places significant responsibility on plan sponsors to manage health benefits transparently and in the best interest of employees. However, many employers may not be fully aware of the risks associated with failing to meet these obligations.

The CAA has introduced new requirements for employers, including requiring disclosure of drug prices for the top 50 drugs and conducting a plan assessment that meets the fiduciary obligation of managing the plan for the benefit of employees. This goes beyond simple compliance—it requires a comprehensive review of health plan operations.

Many employers have relied on their brokers and consultants or health plans to create the attestation required by this regulation. However, there is growing concern that these attestations may not be complete or fully satisfy the requirements. Employers must take ownership of the process to avoid gaps in compliance, which could lead to legal exposure.

To fully review plan operations and identify issues, employers must conduct periodic reviews and audits of plan performance.

Actionable Steps for Employers

➔ Conduct a full PBM Plan Audit

The leading practice is to conduct a full plan audit—not merely reviewing snippets of data but rather running a full claim analysis, ideally over 18–24 months. This type of audit helps identify not only pricing discrepancies but also potential fraud, waste, or abuse in the plan management or questionable practices by service providers, pharmacies, or prescribers.

Many employers are apprehensive about what they might learn in reviewing plans through an audit, but the risk of litigation is too high to continue ignoring the fiduciary duty of ensuring the plan is being managed for the benefit of employees. Too many employers believe that the less they know, the less likely they are to be held accountable. Unfortunately, this is a fallacy, as the legal system would likely use this argument to paint a picture of employer neglect and dereliction of fiduciary duty.

➔ Be Vigilant with PBM Contracts

One common challenge employers face is gaining access to their data from health plans and PBMs that impose contractual restrictions and/or fees for data extraction. Some PBMs require approval of data analytics vendors, which creates a conflict of interest. Employers must be vigilant in negotiating PBM contracts to avoid these barriers. The use of independent auditors is critical to ensuring data is not manipulated or hidden in ways that prevent the disclosure of questionable business practices or inappropriate price manipulation.

Through plan audits, employers have been able to identify common price disparities and price optimization in the current environment. Charging

more for infusion drugs administered in hospitals or massive price variability from one pharmacy to another are common practices that some PBMs use to favor certain partners or maximize price spread.

Top 10 Leading Practices for Conducting a Plan Audit

Through the PBM misalignment initiative workshops and other information gathering, employers have prioritized the following:

- 1 Identify** the credits, incentives, and fees collected by the health plan, incentives, and fees collected by the health plan or PBM from third parties for the purchase of products, drugs, devices, and any other supplies required to administer the benefit. These should be disclosed at the procedure or drug level.
- 2 Examine** what other services the health plan or PBM contracted to provide third parties, such as drug manufacturers, providers/hospitals/facilities, wholesalers, distributors, pharmacies, and any others who would be providing services, supplies, or support for the benefit plan.
- 3 Ask** who is on the health plan or PBM pharmacy and therapy (P&T) committee and obtain a copy of all resumes and biographies. How are these members credentialed? How are they selected and how long do they serve? How does the health plan or PBM ensure independence of advice and disclosure of any conflicts of interest (e.g., employment; payments from manufacturers)? How are these individuals compensated?
- 4 Require** the disclosure of all data elements in claim records, including all financial transaction data, for analysis. Require access to data within 60 days of request.
- 5 Conduct** a fraud, waste, and abuse audit annually to investigate improper, duplicate, fraudulent, or otherwise suspicious payments to any recipient. This audit should include all claims, not just sample datasets.
- 6 Conduct** a spot audit of prior-authorization processes and review blinded samples of clinical documentation to ensure compliance with plan guidance and appropriate clinical protocols. Obtain copies of prior authorization process documentation, decision criteria, and disposition statistics.
- 7 Compare** financial data and pricing to publicly available pricing data (e.g., cash prices or TiC (transparency in coverage) hospital price files) to determine the reasonableness of payments.
- 8 Compare** drug pricing and payments between the medical and pharmacy benefits to determine whether facilities are overcharging for similar products. Use the ingredient costs where possible.
- 9 Conduct** a deep dive into high-cost claims (e.g., >\$10k pharmacy claims), where the most expensive drugs are used. Use the top 50 drugs by unit price or by drug spending to determine which to examine.
- 10 Require** copies of both the formulary and the policies and procedures that govern drug placement in tiers. Determine whether decisions for formulary placement are made based on clinical criteria or financial criteria.



Conclusion

When done in alignment with employers' interests, PBMs provide a valuable service to employers in managing pharmacy benefits. Consolidation and vertical integration have created a health plan environment where certain business practices, like potential self-dealing, lack of transparency, and assumed price manipulation, are driving misalignment with employer requirements and fiduciary duty to manage the pharmacy plan for the benefit of employees.

Employers are fragmented and, in some cases, too small or under-resourced to address these issues.

As innovative solutions like cell and gene therapies and precision medicine transform healthcare, the

need to control costs by aligning costs with value and drive price transparency becomes even more critical. The ability to offer employees access to life-changing and, in some cases, life-saving medications relies on the fair use of employee and employer premiums to deliver the highest value at the lowest cost. This Initiative provided a forum for employers to put their heads together, learn from one another, and identify opportunities to use their leverage to improve PBM accountability and transparency. Without more active management and accountability from PBMs, the promise of life-changing or potentially curative therapies will devolve into a missed opportunity.



Appendix

About the Employer Workshops

During the employer workshops, the focus was on gaining a deeper understanding of the current state of pharmacy benefits and PBMs practices that may not align with employer needs and requirements.

To accomplish this, we developed an agenda focused on:

- ▶ Establishing a [baseline of understanding](#) around PBM misalignment (**current state view**)
- ▶ Reviewing **actions taken** by employers or their coalition partners
- ▶ Developing a key set of [guiding principles](#) for employers to follow when contracting for PBM services (**ideal future state**)
- ▶ Developing a [vendor engagement template](#) with actionable recommendations for employers around PBM partners
- ▶ Developing metrics (**success measures**) to hold PBM partners accountable

We asked employers these questions to solicit insights into their current state:

- ▶ What activities have you undertaken around PBM misalignment?
- ▶ What are the needs/gaps that are not being addressed?
- ▶ What are the minimum requirements for PBM services?
- ▶ What do we want PBMs to do differently?
- ▶ What steps do employers need to take to close gaps?

High-Level Employer Concerns

The key issues we uncovered focused on several high-level areas that we needed to explore in greater depth to identify viable solutions:

- ▶ **Owning the relationship**—expecting access to and the ability to change things like formularies, claims data, insight into price transparency, and incentives like rebates.
- ▶ **Trusted advisors**—working with advisors who were both expert and independent.
- ▶ **Plan performance reviews**—conducting periodic performance reviews or audits to identify and remediate issues and to identify potential fraud, waste, or abuse.
- ▶ **Contract terms and conditions**—the ability to own and change contract provisions and benefits design without resistance or financial penalties.

The top concerns that the groups prioritized and developed recommendations to address were:

1. Promotion of higher-price drugs when lower-price drugs are available.
2. Coverage and/or preference of a brand when a generic or biosimilar is available.
3. Coverage of specialty drugs for circumstances that clinical evidence does not support (e.g., “off-label use”).
4. Automated approval process for prior authorizations that causes rates to soar over 90%.
5. Redefining generics as brand drugs or vice-versa to influence (i.e., meet/reduce) guaranteed pricing discounts.

6. Systematic approaches to encourage waste (e.g., refill too soon, automatic 90-day refill).
7. Coverage of high-cost, low-value drugs (e.g., drugs that have less expensive over-the-counter alternatives).
8. Replacing drugs eligible for rebates with 340B drugs not eligible for rebates, without passing through the substantially lower price of 340B drugs to the employer (continuing to charge plan sponsors and patients the same inflated list price).
9. Narrow definition of “rebates,” which allows the PBM to “pocket” 50% or more of the manufacturer revenue because they have been recharacterized as something else.
10. Plan sponsors being “held hostage” on all PBM contract terms, financial guarantees, and provisions, regardless of the magnitude or changes desired by the benefit plan (formulary changes, carve out of proprietary services, modifications to utilization management).

National Alliance Resources

- [Case Studies: Coalitions and Employers are Disrupting the PBM Misalignment Status Quo](#)
- [Pharmacy Benefit Management: Vendor Engagement Template](#)
- [Employer Playbook on Addressing Pharmacy Benefit Management Misalignment](#)
- [Employer Playbook on Biosimilars](#)
- [Employer Playbook on Prescription Digital Therapeutics](#)
- [Employers Beware: Alternative Funding Programs Require Careful Review to Avoid Negative Consequences](#)
- [Time to Act: Understanding PBM Practices Enables Employers to Ignite Change](#)

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For over 30 years, the National Alliance has united business healthcare coalitions and their employer/purchaser members to achieve high-quality care that improves patient experience, health equity, and outcomes at lower costs. Its members represent private and public sector, nonprofit, and labor union organizations that provide health benefits for more than 45 million Americans and spend over \$400 billion annually. To learn more, visit nationalalliancehealth.org and connect on [LinkedIn](#).