How Opaque is your PBM?

Background

PBMs have operated as opaque intermediaries in the benefits ecosystem for decades and double-digit cost increases for pharmacy are changing that dynamic.

As medical and pharmacy costs are projected to rise nearly 9% and 12% respectively in 2026—driven largely by higher utilization, rising site-of-care costs, and the rapid growth of biologic and specialty drug therapies—employers are taking a harder look at how pharmacy benefits are managed. Employees, in turn, are pushing HR and benefits leaders to act more responsibly as fiduciaries and demonstrate prudent stewardship of plan assets.

At the center of the scrutiny are the "Big Three" pharmacy benefit managers: CVS Caremark, Express Scripts, and OptumRx. Employers are increasingly questioning their lack of transparency around pricing, rebates, spread pricing, and formulary decisions—particularly when lower-cost alternatives or biosimilars exist.

Meanwhile, alternative pharmacy models are gaining traction. Organizations such as Amazon Pharmacy and Mark Cuban's Cost Plus Drugs are attracting employer interest by offering simplified pricing, reduced markups, and far greater transparency. According to Healthcare Finance data , employer use of a major PBM declined from 72% in 2024 to 61% in 2025, while enrollment in alternative pharmacy solutions rose sharply—from 12% to 31% over the same period.

Why Employers Are Leaving the Big Three

1. **Fiduciary risk and litigation exposure**
   ERISA's "duty of prudence" requires plan sponsors to manage benefits responsibly and in the best interest of participants. A recent lawsuit filed by a former employee against Johnson & Johnson alleges the company failed to prudently oversee its PBM, allowing excessive drug pricing. In one example cited, a medication that could be purchased for roughly $30 elsewhere was reportedly billed to the plan at nearly $10,000. Whether or not such cases prevail, they have become a wake-up call for HR and benefits leaders.

2. **Hidden fees, spread pricing, and rebate misalignment**
   Employers are increasingly frustrated by opaque PBM revenue streams—spread pricing, administrative fees, and rebate arrangements that are not fully disclosed. In many cases, PBMs are financially incentivized to favor higher-cost brand drugs over lower-cost generics or biosimilars because rebates are tied to list price, not net cost. The result: higher overall spend for employers and plan participants.

3. **Misaligned incentives in drug selection**
   When PBMs retain rebates tied to expensive medications, employers need to question whether formulary decisions are being made in the best interest of their plan. As biosimilars and therapeutic alternatives expand, employers should be less willing to accept explanations that prioritize rebate guarantees over total cost of care.

Major Actions Taken

- **Blue Shield of California:** In August 2023, BSC announced they would be leaving CVS Caremark as its primary PBM in favor of a modular approach using multiple partners like Amazon Pharmacy, Mark Cuban Cost Plus Drug Company, Abarca, and Prime Therapeutics. This change alone was expected to save them $500 million annually.
- **State of Connecticut:** Renegotiated its contract with CVS and demanded 100% of rebates be passed back to the state and eliminated spread pricing, saving an estimated **$70 million annually**.
- **FTC Pressure:** The Federal Trade Commission (FTC) is currently suing the Big Three PBMs for anticompetitive practices, specifically regarding insulin prices, which has emboldened employers to challenge their existing contracts.

2026 and Beyond

This shift is not temporary. According to WTW, 75% of employers plan to rebid their PBM contract by 2027, with transparency, pass-through pricing, and fiduciary alignment at the top of the requirements list. New and emerging PBM and pharmacy models are here to stay—and their growth will continue to pressure incumbent PBMs to reduce costs, simplify pricing, and operate with far greater transparency.

For employers, the message is clear: pharmacy benefits can no longer be managed on autopilot. The strategy forward is increased scrutiny, stronger governance, and alternative models as the new standard.

How Optimatum Can Help:

Optimatum's clinical and vendor management experts routinely conduct pharmacy utilization forensic analyses and comprehensive PBM contract reviews to identify optimization opportunities. We then design and implement targeted strategies, programs, service-level agreements (SLAs), and performance guarantees (PGs) that maximize value, control costs, strengthen vendor relationships, and deliver meaningful benefits for your employees.

Resources

https://www.healthcarefinancenews.com/news/employers-increasingly-eyeing-more-transparent-pbms?utm

https://www.benefitspro.com/2025/12/15/why-hr-leaders-cant-wait-any-longer-to-rethink-their-pbm/

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https://www.mmm-online.com/news/pbms-pharmacy-benefit-managers-erisa-lawsuit-mark-cuban-cost-plus

https://www.jonesday.com/en/insights/2024/03/fiduciaries-beware_employer-health-plan-under-fire