

How to Fight Your PBM. *For the People Whose Names Are on the Prescriptions.*

A field manual in eight moves for the plan sponsor who has decided that procurement is not a negotiation, that the contract is not a formality, and that the workers in the plan are not the contract's collateral damage but its purpose.

Jeremiah Franklin Shrack

Founder, Kincaid IQ

May 2026

You are not negotiating with your PBM. You are signing a draft they wrote, reviewed by a consultant they compensate, against benchmarks they curate, on terms a hundred prior plan sponsors have already taught them how to defend. By the time you are “at the table,” the table belongs to them.

The fight does not start at the table. It starts before the RFP is written. And the question that determines whether you ever actually fight at all is whether you understand, on day one, who you are fighting and on whose behalf.

You are fighting an architecture. You are fighting on behalf of the worker whose name appears on the prescription — the one who is not in the room, has not seen the contract,

and is the only party at risk in any way that materially compounds. **This is the field manual.**

Orientation: The Procurement Frame Is the Problem

Most plan sponsors believe they negotiate with their PBM. They do not. They participate in a procurement ritual whose architecture, vocabulary, scoring rubric, and timeline have been engineered, over decades, by the counterparties they are nominally bidding against. The RFP template is recycled. The benchmarks are curated. The discount guarantees are quoted against a definition of “ingredient cost” that is itself a structure the PBM produced. The pricing tables are responsive in form and unreviewable in substance. The consultant is paid, somewhere on the cap table, by the bidders.

This is not a moral indictment. It is a structural description. A market in which one side authors the contract, the analytical framework, the data infrastructure, and the comparison set is not an arm’s-length market. It is a one-sided market wearing the costume of a two-sided one.

Fighting begins when the plan sponsor stops acting like a buyer and starts acting like a fiduciary. Buyers compare offers. Fiduciaries inquire into structure. The two activities look similar from across the room. They produce radically different outcomes for the worker.

The PBM’s favorite plan sponsor is the one who shows up to renewal with a one-page consultant scorecard, a percentage-discount guarantee, and a question about administrative fees. That sponsor does not need to be defeated. That sponsor has already done the work.

The Eight Moves

Each of the moves below disables a specific architectural mechanism in the contract you are otherwise about to sign. Each is testable, contractible, and discoverable. None of them is novel. All of them have been resisted by every major PBM in market, in language only their counsel finds neutral. **The fight is not whether to make these moves. The fight is whether the plan sponsor will make them before the renewal calendar makes them politically impossible.**

MOVE 01

Identify Your Real Counterparty. It Is Not One Entity.

You are not negotiating with a vendor. You are negotiating with a vertically integrated stack: the wholesale distributor, the GPO that aggregates manufacturer rebates (often a wholly-owned PBM subsidiary, often domiciled offshore), the specialty pharmacy (often PBM-owned and channel-locked), the mail-order pharmacy (likewise), the retail network the PBM credentialed, the formulary committee whose membership is influenced by the PBM, the data subsidiary that monetizes your claims, and the consulting firm whose vendor-relations team is compensated through overrides not reflected on your invoice.

Require, as a pre-RFP condition, full disclosure of every legal entity affiliated with the PBM that will receive compensation, in any form, attributable to your plan. Not “owned subsidiaries.” Every entity. Every form. Every dollar. Including the ones that do not appear on the contract you sign.

WHY IT MATTERS TO THE WORKER The architectural revenue captured by the unnamed nodes is the architectural revenue not flowing back into the plan, and therefore into the participant’s out-of-pocket cost. A PBM that cannot map its own corporate organism for a \$50M-spend plan sponsor has answered, by declining to answer, the question of where the worker’s dollars are going.

MOVE 02

Replace Procurement-by-Template With a Disclosure-First RFP.

The conventional RFP asks for guarantees. AWP discount, dispensing fee, rebate-per-script, generic effective rate, brand effective rate. Each is reported as a single number, against a

definition the PBM controls, in a column the consultant scores. This is not an RFP. It is a customer satisfaction survey administered by a counterparty.

Restructure the RFP around disclosure. Require the bidder to itemize: every revenue stream attributable to the plan; every retained spread mechanism, even if “passed through” in label; every administrative fee credited against rebates; every GPO retention; every data monetization line; every specialty channel margin; every formulary placement consideration; every manufacturer payment, by category, by NDC tier, by therapeutic class. Score the responses on completeness of disclosure, not on the marketing chart on page two.

WHY IT MATTERS TO THE WORKER An RFP that scores guarantees rewards the PBM that engineered the most defensible guarantees. An RFP that scores disclosure rewards the PBM that retained the fewest hidden margins. The first procurement frame buys you a number. The second one buys your worker fewer dollars extracted at the counter.

MOVE 03

Define the Definitions Before They Are Weaponized.

The PBM contract is an exercise in controlled vocabulary. AWP, NDC, MAC, Generic, Brand, Single-Source Brand, Specialty, Rebate, Manufacturer Payment, Administrative Fee, Network Access Fee, Pharmacy Price Concession, Effective Rate, Plan Cost, Plan Spend. Each is a term of art. Each is a dial. Each can be turned, in either direction, to compound or relieve fiduciary exposure, depending on whose draft is in front of you.

The single highest-leverage hour in any PBM negotiation is the hour spent rewriting the definitions section. Source AWP from a publication the PBM does not own. Define MAC governance: who sets the methodology, who audits it, who arbitrates disputes, on what timeline, with what data delivered in what format. Define “Specialty” with reference to NDC-level criteria, not the PBM’s internal “Specialty Drug List” (which is editable). Define “Generic” in a way that does not allow authorized generics, branded generics, or single-source generics to be reclassified mid-term. Define “Rebate” to include any payment, however labeled, from a manufacturer or its agent, attributable to the utilization of the plan’s lives.

SAMPLE CONTRACT LANGUAGE

“Rebate” means any and all consideration, monetary or non-monetary, paid by, or on behalf of, any pharmaceutical manufacturer (or its affiliates, agents, or successors) to PBM, or to any PBM Affiliate, in connection with the utilization, formulary placement, market share, claims volume, or therapeutic substitution of any product dispensed to any covered participant of the Plan, whether characterized by the recipient as a rebate, discount, administrative fee, network access fee, formulary placement fee, market share incentive, price protection, data fee, education grant, or any other label, present or future. Plan Sponsor shall be entitled to one hundred percent (100%) of all such consideration, on a per-claim basis, with manufacturer-direct verification rights.

WHY IT MATTERS TO THE WORKER The participant’s coinsurance is calculated against the contract’s definitions, not against retail reality. Tighten the definitions and the coinsurance compresses. Leave the definitions loose and the worker pays the slack.

MOVE 04

Demand Audit Rights That Survive Contact With the Contract.

Most PBM contracts grant audit rights that are technically present and operationally inert. Statistical sampling at **2–5%** of claims. A “mutually agreed” auditor (selected from a list the PBM maintains). A look-back window so short it expires before suspicion ripens. Carve-outs for “proprietary methodologies” that exclude the methodology you are auditing. NDA scope so broad the fiduciary cannot share findings with co-fiduciaries or counsel. A finding-resolution clause that lets the PBM dispute the audit indefinitely.

Replace this entire architecture. Require **100% claim-level audit rights**, not statistical sampling. Reserve the auditor selection unilaterally to the plan sponsor. Reserve a look-back of no fewer than **twenty-four months**, with a tolling clause for any concealment. Forbid “proprietary methodology” carve-outs by name. Require data delivery in machine-readable, NDC-level, claim-line format with cost-of-goods inputs disclosed. Restrict NDA scope to legitimate trade secrets, with explicit carve-outs for fiduciary disclosure obligations under ERISA and for regulatory inquiry.

WHY IT MATTERS TO THE WORKER A contract you cannot audit is a contract you cannot defend. A contract you cannot defend is a fiduciary breach waiting for a plaintiff. The cost of that exposure does not stay on the corporate balance sheet. It surfaces, eventually, as the next renewal's premium, the next year's benefit cut, the participant's next coinsurance increase.

MOVE 05

Move From “Rebate Guarantees” to Rebate Verification.

The rebate guarantee is the most successful piece of misdirection in modern benefits procurement. The PBM offers a number per script, or per brand script, or per “rebateable” script. The plan sponsor signs. Two years later, the PBM's parent reports a rebate-related revenue line that does not reconcile, by any plausible arithmetic, with the guarantees the plan sponsor was promised.

The guarantee was paid. The architecture was not disclosed. The reconciliation does not occur because the contract did not require it.

Replace the guarantee with verification. Require **100% pass-through** of all manufacturer payments (per the broadened definition in Move 03), with a sponsor-level audit trail to manufacturer wires, on a per-NDC, per-claim, per-period basis. Require the GPO chain of custody, including any offshore aggregator, to be disclosed. Forbid the retention of any portion of any manufacturer payment as “administrative fee,” “network access fee,” or any synonym whose structural function is the same.

WHY IT MATTERS TO THE WORKER Every manufacturer dollar retained by the PBM is a dollar not returned to the plan, which is a dollar not credited against the participant's deductible accumulator, which is a dollar the participant pays at the counter. Rebate retention is a private transfer from the plan participant to the PBM's shareholders. The contract architecture is the transfer mechanism.

Prohibit Spread Pricing in Language the PBM Cannot Redefine.

“Pass-through” is not a contract term. It is a marketing term. The structural reality of pass-through depends entirely on what the contract permits to be retained outside the pass-through line. Most pass-through contracts in market today permit the PBM to retain margin via mail-order channel transfer pricing, specialty pharmacy markup, formulary placement fees recharacterized as administrative fees, MAC list spread on generics not subject to AWP discount, and a half-dozen other mechanisms that are, definitionally, spread — just not labeled as such.

Prohibit spread by mechanism, not by label. Require the contract to state, in operative language, that the PBM and any affiliate shall receive no compensation, in any form, attributable to the difference between the price paid by the plan and the price received by, or recognized at, the dispensing pharmacy. Define “dispensing pharmacy” to include PBM-owned mail-order and specialty channels at their internal cost-of-goods. Make the prohibition self-executing: any retained spread, by any name, is a refundable overpayment recoverable on demand, with interest.

SAMPLE CONTRACT LANGUAGE

PBM shall earn no compensation, monetary or non-monetary, by any name or mechanism, from any difference between the price paid by Plan for any prescription drug claim and the actual cost of acquisition of such drug by the dispensing pharmacy, including any pharmacy owned, controlled, or affiliated with PBM. Any such difference, however characterized, shall be deemed a refundable overpayment, recoverable by Plan on written demand together with interest at the federal short-term rate plus two percent (2%), and shall not be subject to any offset, contractual limitation, or audit-finding dispute resolution clause that would delay or reduce recovery.

WHY IT MATTERS TO THE WORKER Spread pricing is a hidden tax on every claim. The participant pays a percentage of an inflated price; the PBM keeps the inflation. Removing the spread does not lower the listed price — it lowers the participant’s coinsurance against it. The worker feels it on the next refill.

Assign Fiduciary Status Explicitly. Then Name the Participant in the Contract.

The PBM's standard contract goes to substantial length to disclaim fiduciary status under ERISA. The disclaimer is, in many cases, contradicted by the conduct: the PBM exercises discretion over formulary placement, prior authorization, MAC governance, network composition, audit findings, and rebate allocation. ERISA's functional fiduciary doctrine — *Section 3(21)(A)(i)* — does not turn on what the contract says. It turns on what the entity does.

Refuse the disclaimer. Where the PBM exercises discretion over plan assets or plan administration, require the contract to acknowledge the corresponding fiduciary status, with the corresponding indemnification, insurance coverage, and standard of care. Where the PBM declines to acknowledge it, the conduct does not stop being fiduciary; it merely stops being insured. Document the refusal in the procurement file. The procurement file is discoverable.

Then go further: name the participant in the contract as the protected interest. Most PBM agreements treat the participant as an external dependent of the agreement. Restructure the recitals and the standard of performance to identify the participant as the intended beneficiary of every material obligation. The legal effect is modest. The signaling effect, when discovery arrives, is significant. **The contract that identifies the worker as its purpose is the contract that survives a participant-led complaint.**

WHY IT MATTERS TO THE WORKER A PBM that contractually disclaims fiduciary status while exercising fiduciary discretion is operating in a posture that, in litigation, will be reframed as the operative posture, not the disclaimed one. The participant who is named in the contract as a protected interest has a place to point on the page. That point is what a complaint is built around.

MOVE 08

Build Termination Optionality Without Ransom.

The standard PBM contract is engineered to make exit costly. Multi-year terms with auto-renewals. Termination-for-cause thresholds set so high that demonstrable underperformance does not satisfy them. Termination-for-convenience clauses that void rebate guarantees, claw back administrative credits, and impose data-transition fees that approximate a year's administrative budget. Implementation provisions in the successor PBM that take six to nine

months to operationalize because the incumbent “owns” the eligibility data, the prior-authorization history, and the formulary mapping.

Negotiate termination without ransom. Reserve **termination for convenience on ninety days’ notice**, with no clawback of guarantees earned through the termination date. Require, at execution, a **data portability appendix** specifying the format, frequency, and ownership of all eligibility, claims, prior-authorization, formulary, and pricing data — with a contractual obligation to deliver in machine-readable form, on demand, at no additional cost, including post-termination. Forbid transition fees that exceed reasonable, documented out-of-pocket cost.

WHY IT MATTERS TO THE WORKER A plan sponsor that cannot leave is a plan sponsor that cannot fight. A plan sponsor that cannot fight is one whose participants will absorb the consequences of every contract term that subsequently turns out to favor the counterparty. Optionality is not a luxury. It is the precondition for fiduciary credibility.

The Move That Is Not on the List

The eight moves above are the ones a plan sponsor can negotiate. There is a ninth move, which the plan sponsor cannot negotiate but must perform: **read the receipt the worker holds**.

The most under-examined document in the entire pharmacy benefit architecture is the printout from the pharmacy counter. It is the only document the participant possesses. It is the document on which her actual out-of-pocket cost is recorded. It is the document that, reconciled to the plan’s claim-level data, tells the truth about what the contract did to her wage, in real dollars, on a real day, against a real prescription she filled because a clinician told her she needed it.

The plan sponsor who has never reconciled a participant’s pharmacy receipt to the corresponding claim line in the PBM’s data feed has not yet started fighting. Everything before that step is procurement. The fight begins at the counter.

The CFO's deck shows the plan's aggregate spend trended over five years. The participant's receipt shows what was actually charged at **7:42 p.m.** on a Tuesday at the pharmacy nearest her house. Both are real. Only one of them appears in the renewal review. The other one is on her refrigerator.

THE LITIGATOR TAKE – PROCUREMENT IS NOW DISCOVERY

The plaintiffs'-bar migration from the 401(k) excessive-fee context into the health and welfare context is no longer a forecast. It is a docket. The complaints filed against named fiduciaries of large self-funded plans in the past eighteen months are not pleading speculation. They are pleading specific architectural mechanisms — spread pricing on generics, rebate retention through GPO subsidiaries, formulary manipulation tied to specialty channel margin, MAC list disputes resolved without participant remedy — and they are pleading them with the contract attached as an exhibit.

The defense in those cases will not turn on whether the PBM's pricing was "competitive." It will turn on whether the named fiduciary inquired into the structure of the contract with the level of diligence that ERISA Section 404(a)(1)(B) requires. The eight moves above are not aspirational best practices. *They are, in aggregate, the procurement record a competent plaintiff will demand to see in order to evaluate whether the duty of prudence was discharged.* The procurement file is discoverable. The RFP is discoverable. The consultant's scoring memorandum is discoverable. The internal correspondence in which the plan sponsor accepted the PBM's redlined definitions section without contest is discoverable.

The defense window is not closing because the law is changing. The law has not changed. The defense window is closing because **the analytical infrastructure required to know what the contract did to the participants is no longer unavailable.** Once the infrastructure exists, the duty to use it follows. The fiduciary who could not have known in 2018 is not the fiduciary who signed in 2026. The standard of inquiry the duty of prudence

requires is calibrated to what is, at the time of the decision, available to a prudent fiduciary acting under like circumstances. What is available has changed.

If these facts are borne out in discovery against the contracts in market today, the question is not whether there is exposure. The question is which plan sponsors fought the contract before the complaint, and which plan sponsors are now reconstructing the fight from the witness chair. *Both groups will end up doing the same work. Only one of them will do it in time.*

STEWARDSHIP – THE WORKER IS THE PURPOSE, NOT THE MARGIN

You Are Not Fighting for a Better Number. You Are Fighting for a Person Whose Name Is on a Bottle.

It is worth saying plainly what the procurement framing does not. Each of the eight moves above is a tactical instrument. Each can be drafted, redlined, executed, and audited. None of them, individually or in aggregate, is the reason any of this matters. The reason any of this matters is that, in every plan a sponsor administers, there is a worker — a diabetic on insulin, a cancer patient on a specialty therapy, a parent filling an inhaler for a child — whose financial life is, on a given day, materially affected by clauses in a document she has never seen, in a contract she did not sign, between counterparties whose interests are not hers.

The Wesleyan tradition in which I was formed treats stewardship as a moral structure, not a metaphor. A steward is the trustee of resources that are not his own, accountable to the one whose interests the resources are held for. *“Well done, good and faithful servant; you have been faithful over a few things, I will make you ruler over many.”* The parable of the talents in *Matthew 25* is not a parable about return on capital. It is a parable about the moral weight of intermediation. The steward who buries the talent has not stolen it. He has failed in the duty owed to the one who entrusted it. ERISA, in 1974, codified that ancient duty into statute. The plan administrator, as fiduciary, is a steward. The plan assets are not the steward’s. The duty is owed to the worker whose name is on the prescription.

When Solomon, in *1 Kings 3*, was offered any gift and asked instead for an understanding heart to discern between right and wrong, to govern the people entrusted to him, the request was not abstract piety. It was the recognition that the position he held was, structurally, a stewardship over lives he did not own. The plan sponsor occupies a smaller version of that same position. The benefit envelope is not the sponsor's. It is the workers'. The PBM contract is the place where the stewardship is most often quietly compromised, because it is the place the analytical infrastructure has historically been weakest. **The plan sponsors who will be remembered well in this cycle are not the ones who hit their pharmacy budget. They are the ones who fought the contract on behalf of the people whose names appeared on the prescriptions, before anyone made them.**

The dignity of labor is not a slogan. It is the structural premise on which the wage was authorized in the first place. When the wage does not arrive at the counter — when the contract intercepts it through six architectural mechanisms the worker has never been shown — the premise has been violated. The plan sponsor is in the unique position to close that violation, because the plan sponsor controls the signature, the budget, and the analytical capacity required to read the contract at clause level. The duty is not new. The tools to discharge it are.

FORWARD VIEW

A Renewal Is Not a Date on the Calendar. It Is a Test of What You Knew.

The next twenty-four months will produce a sorting. Plan sponsors who continue to evaluate PBM contracts on the visible invoice, against guarantees the PBM authored, on benchmarks the PBM curates, will be evaluated — in deposition, in the financial statements, in the next renewal cycle, in their workforce's retention numbers — against an analytical regime that did not exist when they signed. The CAA 2021 disclosure architecture, the DOL's sharpening of health plan fiduciary guidance, the maturation of NDC-level participant-cost reconstruction, and the

migration of plaintiffs’-bar attention to the health-and-welfare context are converging. None of those movements is speculative. All of them are operational now.

The legal evaluation of a PBM contract signed in 2025 will not be conducted using the analytical infrastructure available in 2025. It will be conducted using the infrastructure available in the year of the evaluation. The fiduciary who signed under one informational regime will be evaluated under a later one. The question on examination will not be whether the procurement was “competitive.” The question will be: *did the fiduciary deploy the inquiry the duty of prudence required, when the inquiry was available, on behalf of the participants whose interests the fiduciary was statutorily obligated to protect?*

The eight moves are not a recipe. They are a posture. They describe what it looks like when a plan sponsor stops being a buyer and starts being a fiduciary. The PBM that resists each of them has, by the resistance, identified itself. The PBM that accepts each of them, in operative language, on the contract face, with no counsel-side carve-outs, has identified itself in the opposite direction. **The procurement record will, eventually, be read aloud. The only question is by whom, and in what tone of voice.**

Fight the contract. Fight it before you sign. Fight it on behalf of the worker whose name appears on the prescription, who is not in the room, who has not seen the document, and whose household budget is, between renewals, the silent counterparty to every clause you accepted without contest. The fight is not loud. It is a redline, on a Tuesday afternoon, in a definitions section a consultant told you was “standard.” That is where the fight is. That is also where the people are.

By Jeremiah Franklin Shrack

Founder, Kincaid IQ — Co-Founder, Kincaid Risk Management Consultants
Architect, Rx Defense PBM Contract X-Ray

RX DEFENSE PBM CONTRACT X-RAY

Kincaid IQ is a fiduciary-grade Rx and health transparency engine built for plan sponsors, capital markets, and boards. Rx Defense PBM Contract X-Ray delivers clause-level PBM contract intelligence to surface fiduciary risk, spread pricing mechanics, audit right limitations, and rebate opacity — so the people responsible for these contracts can actually answer the questions ERISA requires.

This content is for informational and educational purposes only and does not constitute legal, financial, or actuarial advice. Consult qualified counsel for guidance specific to your situation.