PBM CONTRACT CLARITY 360™ · FIDUCIARY-GRADE PBM INTELLIGENCE

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August 9, 2026
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PBM CONTRACT FIDUCIARY ANALYSIS REPORT

Prime Therapeutics Management LLC

2025.01 ASA SIGNED (Prime) (6).pdf

37
OUT OF 100

RED FLAG

CAA 2026 Fiduciary Alignment Score
65 Issues · 13 Provisions Evaluated

4	35	26	13
CRITICAL FLAGS	ISSUES NOT MET	PROTECTIONS FOUND	PROVISIONS ANALYZED

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SECTION 1

Critical Issues Ranked by Priority

The following 35 unmet requirements are ordered by fiduciary risk. Items are ranked using a weighted formula incorporating provision severity rating and CAA 2026 compliance priority. Address items in this order for maximum fiduciary protection.

01 **Explicit spread pricing clauses** RED FLAG

Provision 2: Spread Pricing

GAP

No explicit prohibition that plan charges equal pharmacy reimbursements plus disclosed admin fee.

02 **Hidden spread via pharmacy clawbacks** RED FLAG

Provision 2: Spread Pricing

GAP

No prohibition of DIR fees/GER reconciliations reducing pharmacy pay after adjudication.

03 **PBM rebate retention rights** RED FLAG

Provision 3: Rebates & Manufacturer Revenue

GAP

No explicit 100% pass-through of all manufacturer-derived revenue (formulary, admin, data, price-protection, inflation, guarantees).

04 **Delayed rebate remittance timing** RED FLAG

Provision 3: Rebates & Manufacturer Revenue

GAP

No remittance deadlines or interest on late payments.

05

Limited audit scope clauses RED FLAG

Provision 7: Audit Rights & Recovery

GAP

No affirmative audit scope defined; risk PBM restricts to summary reports.

06

Short audit lookback windows RED FLAG

Provision 7: Audit Rights & Recovery

GAP

Lookback not stated; PBM can limit to 6-12 months.

07

Data access restrictions during audit RED FLAG

Provision 7: Audit Rights & Recovery

GAP

No right to de-identified claim-level and contract/manufacturer documentation.

08

Recovery limitations post-audit RED FLAG

Provision 7: Audit Rights & Recovery

GAP

No interest on recoveries or mandatory timing.

09

PBM-controlled audit methodology RED FLAG

Provision 7: Audit Rights & Recovery

GAP

No sponsor right to select auditor or define sampling.

10

Lack of ingredient cost disclosure RED FLAG

Provision 8: Transparency & Disclosure

GAP

No claim-level pharmacy paid ingredient and DF disclosure to sponsor.

11 **Non-itemized claim-level visibility** RED FLAG

Provision 8: Transparency & Disclosure

GAP

No commitment to provide full NCPDP fields necessary to reconcile pricing and rebates.

12 **Weak or non-binding performance quality levels (PQLs)** RED FLAG

Provision 9: Performance Guarantees

GAP

No PQLs stated (call center, turnaround times, prior auth SLAs).

13 **Utilization threshold manipulation** RED FLAG

Provision 9: Performance Guarantees

GAP

No guarantee definitions for generic dispensing rate, formulary compliance, biosimilar uptake.

14 **Bonus-driven misalignment incentives** RED FLAG

Provision 9: Performance Guarantees

GAP

No alignment of PBM bonuses to sponsor net cost.

15 **Penalty avoidance loopholes** RED FLAG

Provision 9: Performance Guarantees

GAP

No liquidated damages or dollar-at-risk tied to measurable outcomes.

16 **Early termination penalties** RED FLAG

Provision 10: Termination & Exit Barriers

GAP

No termination rights/penalties listed; risk of punitive fees.

17 **Data export restrictions upon exit** RED FLAG

Provision 10: Termination & Exit Barriers

GAP

No obligation to provide complete historical data in standard formats.

18 **Contract lock-in renewal structures** RED FLAG

Provision 10: Termination & Exit Barriers

GAP

No auto-renewal notice windows specified.

19 **Financial penalties for switching PBMs** RED FLAG

Provision 10: Termination & Exit Barriers

GAP

No penalty language visible; risk remains.

20 **Explicit fiduciary duty disclaimers** RED FLAG

Provision 12: Fiduciary & Legal Protections

GAP

No fiduciary duty acceptance to act in Sponsor's best interest.

21 **Indemnification asymmetry favoring PBM** RED FLAG

Provision 12: Fiduciary & Legal Protections

GAP

No mutual indemnity terms provided.

22 **Liability limitation clauses** RED FLAG

Provision 12: Fiduciary & Legal Protections

GAP

No caps or carve-outs reviewed; risk of low caps limiting recovery.

23 **PBM ownership of claims data** RED FLAG

Provision 13: Data Ownership & Access Rights

GAP

No explicit Sponsor ownership rights.

24 **Restricted data portability/export rights** RED FLAG

Provision 13: Data Ownership & Access Rights

GAP

No commitment for full raw claim exports in standard layouts.

25 **Spread between reimbursement benchmarks** CONCERN

Provision 1: Pricing & Reimbursement

GAP

No explicit parity between pharmacy reimbursement and plan billing; no guarantee of single-source pricing benchmark alignment across channels.

26 **Specialty drug pricing carve-outs** CONCERN

Provision 1: Pricing & Reimbursement

GAP

No explicit specialty discount guarantees, LDD rate caps, or buy-and-bill parity; PBM-owned specialty channels defined but not price-constrained.

27

Repricing or retroactive adjustments CONCERN

Provision 1: Pricing & Reimbursement

GAP

No protections against retroactive price file changes or backdated MAC updates.

28

Step therapy enforcement control CONCERN

Provision 4: Formulary Control

GAP

No clarity on who sets/approves step and PA rules or appeals standards.

29

Therapeutic substitution discretion CONCERN

Provision 4: Formulary Control

GAP

No constraints on PBM-driven therapeutic interchange programs.

30

Preferred pharmacy steering CONCERN

Provision 5: Pharmacy Network Design

GAP

No disclosure on preferred tiers or cost parity requirements.

31

Site-of-care steering restrictions CONCERN

Provision 6: Specialty Drug Management

GAP

No rights for SOC optimization from hospital outpatient to home/ambulatory infusion.

32

White/brown bagging mandates CONCERN

Provision 6: Specialty Drug Management

GAP

No guardrails; PBM can mandate bagging via owned specialty without price parity or clinical exception path.

33 **Retroactive claim adjustment authority** CONCERN

Provision 11: Claim Adjudication Logic

GAP

No limits on backdated adjustments.

34 **Reversal discretion without notice** CONCERN

Provision 11: Claim Adjudication Logic

GAP

No sponsor notice/approval for reversals.

35 **Claim reprocessing opacity** CONCERN

Provision 11: Claim Adjudication Logic

GAP

No obligation to disclose reprocessed claims and impact.

SECTION 2 · PROVISION 1 OF 10

Pricing & Reimbursement

4.5
OUT OF 10

CONCERN 3 of 6 requirements met

WHY THIS PROVISION MATTERS

CAA 2026 §3101 requires PBM transparency and fiduciary alignment for group health plans. A fiduciary loyalty commitment is the foundational protection for all other contract provisions.

FINANCIAL CONTEXT

Without explicit fiduciary acceptance, the PBM can legally act in its own economic interest — routing volume to owned pharmacies, retaining undisclosed revenue, and making formulary decisions for profit. Plans facing regulatory audit under CAA 2026 without this clause carry significant legal exposure.

FIDUCIARY SIGNIFICANCE

ERISA §404 creates personal liability for plan fiduciaries who fail to monitor the PBM. A contractual fiduciary commitment shifts this burden and creates a private right of action.

ISSUE EVALUATION (6 ISSUES)

⊗ NOT MET — 3 PROTECTIONS MISSING

Spread between reimbursement benchmarks

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No explicit parity between pharmacy reimbursement and plan billing; no guarantee of single-source pricing benchmark alignment across channels.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Without a fiduciary loyalty clause, the PBM's contractual obligation is to itself — not the plan. This means every formulary decision, network design choice, and vendor routing decision can legally be made to maximize the PBM's own economic interest, even when a cheaper option exists for the plan.
2. PBMs exploit this absence by routing volume to their own owned pharmacies, retaining undisclosed manufacturer payments, favoring brand drugs with high rebate revenue over cheaper generics that would cost the plan less, and blocking plan access to claims data needed to discover these practices.
3. When the DOL or a plan participant's attorney asks 'how did you protect the plan's economic interest?', the absence of a fiduciary clause means the plan fiduciary has no contractual answer — creating personal liability for the HR Director, CFO, and any named plan administrator.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

Fiduciary misalignment allows the PBM to legally capture an estimated 3–8% of total drug spend in undisclosed revenue. For a $3M drug spend plan, this represents $90,000–$240,000 per year in value diverted from the plan to the PBM — all contractually permissible without a fiduciary clause.

⚑ RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

```
"PBM acts as an independent contractor and not as a fiduciary of the Plan"
```

```
"Nothing in this Agreement shall create a fiduciary relationship between PBM and Plan"
```

```
"PBM provides services in its capacity as a vendor, not as a fiduciary"
```

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

> Add: "PBM acknowledges it is acting as a functional fiduciary of the Plan within the meaning of ERISA §3(21) with respect to all formulary management, network design, and pricing decisions. PBM shall at all times act in the sole interest of Plan participants and beneficiaries and shall not place its own economic interests above those of the Plan."

Specialty drug pricing carve-outs

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No explicit specialty discount guarantees, LDD rate caps, or buy-and-bill parity; PBM-owned specialty channels defined but not price-constrained.

⚠ HOW PBMS EXPLOIT THIS GAP

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Repricing or retroactive adjustments

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No protections against retroactive price file changes or backdated MAC updates.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Without a fiduciary loyalty clause, the PBM's contractual obligation is to itself — not the plan. This means every formulary decision, network design choice, and vendor routing decision can legally be made to maximize the PBM's own economic interest, even when a cheaper option exists for the plan.
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MET (3)

- AWP/WAC/NADAC benchmark opacity

  > *""Average Wholesale Price" or "AWP" means... published by MediSpan... PBM shall update AWP data no less than weekly."*

- MAC list manipulation flexibility

  > *""Maximum Allowable Cost" or "MAC" means... included on the PBM's MAC List, which may be amended from time to time by PBM."*

- Dispensing fee variability asymmetry

  > *""Dispensing Fee" means the service fee... added to the discounted AWP or MAC. No Dispensing Fee is added to the U&C."*

GAP SUMMARY

Unilateral benchmark and MAC controls enable PBM to set reimbursement economics and extract spread via opaque updates, channel-specific fees, and lack of specialty carve-out caps.

RECOMMENDED CONTRACT LANGUAGE

```
"PBM shall reimburse pharmacies and bill Sponsor at the same unit
benchmark and rate schedule by channel and product class. MAC lists
are fixed for 30 days with weekly published updates, pharmacy
appeal rights (48h response), and Sponsor pre-approval for
methodology changes. Specialty reimbursement shall be no worse than
```

AWP−22% + $0 DF for non−LDD and AWP−17% + $0 DF for LDD; all dispensing fees are fixed per published schedule."

NEGOTIATION TALKING POINT

"Provide last 12 months of MAC add/change/delete logs with effective dates, claim-level impact, and network appeals; specialty claims by NDC with paid rate vs. AWP at adjudication; channel-level dispensing fee schedules and effective dates."

SECTION 3 · PROVISION 2 OF 10

Spread Pricing

3.0
OUT OF 10

RED FLAG 2 of 4 requirements met

WHY THIS PROVISION MATTERS

Spread pricing was banned in Medicaid by CMS in 2020. Self-funded ERISA plans must contractually prohibit it. Pass-through pricing means the plan pays exactly what the pharmacy is paid — no more.

FINANCIAL CONTEXT

Spread pricing is the practice of billing the plan more than the PBM pays the pharmacy, pocketing the difference. For a plan with $3M in annual drug spend, spread pricing commonly adds 5–15% in hidden margin — $150K to $450K per year — with no clinical benefit.

FIDUCIARY SIGNIFICANCE

The Consolidated Appropriations Act (CAA 2022 §204) requires pass-through pricing for Medicaid managed care. ERISA fiduciaries in self-funded plans face similar expectations. Spread pricing in a negotiated contract is a primary driver of inflated pharmacy spend.

ISSUE EVALUATION (4 ISSUES)

⊗ NOT MET — 2 PROTECTIONS MISSING

⊗ Explicit spread pricing clauses

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No explicit prohibition that plan charges equal pharmacy reimbursements plus disclosed admin fee.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Spread pricing is the most straightforward form of PBM profit extraction. The PBM reimburses the pharmacy $4.80 for a generic metformin, then bills the plan $8.20 for the same fill — pocketing the $3.40 'spread' as undisclosed margin. Multiply this across thousands of generic fills per year, and the total hidden cost is staggering.

2. PBMs use Maximum Allowable Cost (MAC) lists as the mechanism for spread pricing. The PBM sets MAC prices paid to pharmacies at one level and bills the plan at a higher level. The MAC list itself is proprietary and not shared with the plan, making it impossible to detect without contractual transparency rights.

3. In 2020, CMS banned spread pricing in Medicaid managed care, citing documented overcharges averaging 9.1% of generic drug cost. Self-funded ERISA plans have no such federal protection — the only protection is contractual, through explicit pass-through pricing requirements.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

For a plan with 500 members and $3M in annual drug spend, generic drugs typically represent 35–40% of spend but 88% of fill volume. At an average spread of $3–8 per generic fill and 15,000 generic fills/year, annual spread pricing cost ranges from $45,000 to $120,000. This is invisible without contractual pass-through pricing and MAC transparency requirements.

⚑ RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

```
"PBM pricing is based on its MAC list, which is proprietary and subject to change"
```

```
"Plan shall pay PBM the amounts set forth in the pricing schedule attached hereto"
```

```
"PBM's ingredient cost reimbursement rates are confidential information"
```

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

> Add: "PBM shall implement pass-through pricing for all pharmacy claims. The amount billed to the Plan for each claim shall not exceed the amount paid by PBM to the dispensing pharmacy for that claim. PBM shall provide Plan with access to the MAC list and pharmacy reimbursement rates upon request. Any retention of the difference between amounts billed to Plan and amounts paid to pharmacies constitutes a prohibited transaction under ERISA §406."

Hidden spread via pharmacy clawbacks

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No prohibition of DIR fees/GER reconciliations reducing pharmacy pay after adjudication.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Spread pricing is the most straightforward form of PBM profit extraction. The PBM reimburses the pharmacy $4.80 for a generic metformin, then bills the plan $8.20 for the same fill — pocketing the $3.40 'spread' as undisclosed margin. Multiply this across thousands of generic fills per year, and the total hidden cost is staggering.

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MET (2)

- Implicit spread via reimbursement gaps

  > *"PBM's MAC Lists and payment/cost schedules are frequently updated. PBM will provide Sponsor with a copy of the MAC List upon request."*

- Spread non-disclosure to plan sponsor

  > *"PBM will provide Sponsor with a copy of the MAC List upon request."*

GAP SUMMARY

No ban on spread and limited disclosure create a structural pathway for rent extraction between plan invoice and pharmacy payment.

RECOMMENDED CONTRACT LANGUAGE

```
"This is a pass-through contract: PBM shall bill Sponsor exactly
the amount paid to pharmacies for ingredient cost and dispensing
fee; PBM compensation limited to an agreed per-claim admin fee. No
DIR/GER or other post-adjudication adjustments retained by PBM."
```

NEGOTIATION TALKING POINT

"Demand a claim-level file (NCPDP fields) with pharmacy paid ingredient, DF, taxes, member cost share, and plan paid for every claim; require reconciliation of plan-billed vs. pharmacy-paid deltas with refund plus interest."

SECTION 4 · PROVISION 3 OF 10

Rebates & Manufacturer Revenue

2.5
OUT OF 10

RED FLAG 4 of 6 requirements met

WHY THIS PROVISION MATTERS

Manufacturer rebates are paid to PBMs as a percentage of drug list price (WAC). 100% pass-through contracts eliminate PBM incentives to favor high-list-price drugs. All forms of manufacturer revenue — not just rebates — must be captured.

FINANCIAL CONTEXT

Most PBMs retain a portion of manufacturer rebates in 'pooled' arrangements — averaging the rebate across all clients rather than passing through each client's earned amount. For a mid-size plan, the gap between pooled and actual rebates can be $75K–$300K/year. Admin fees, grants, data fees, and other manufacturer payments are rarely disclosed or remitted.

FIDUCIARY SIGNIFICANCE

The DOL Field Assistance Bulletin 2021-02 confirmed that failing to capture all manufacturer revenue is a breach of fiduciary duty. Rebates are often 20–40% of gross drug cost on brand medications.

ISSUE EVALUATION (6 ISSUES)

⊗ NOT MET — 2 PROTECTIONS MISSING

PBM rebate retention rights

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No explicit 100% pass-through of all manufacturer-derived revenue (formulary, admin, data, price-protection, inflation, guarantees).

⚠ HOW PBMS EXPLOIT THIS GAP

1. Manufacturer rebates are not just one pool of money — they are a complex ecosystem of payments including per-unit rebates, market share bonuses, performance bonuses, administrative fees, data fees, and 'educational grants.' PBMs negotiate all of these in their own name, collect them from manufacturers, and the contract language that determines what passes through to the plan is almost always favorable to the PBM.

2. The most common exploitation technique is 'pooled rebate' arrangements, where the PBM averages rebates across its entire book of business rather than allocating the actual rebates earned by this plan's members. A plan with a high concentration of Humira or Ozempic users may have earned $300,000 in actual manufacturer rebates but receive only $180,000 under a pooled arrangement — with no visibility into the gap.

3. Beyond rebates, PBMs receive manufacturer payments they categorize as 'administrative fees,' 'data license fees,' 'pharmacy services fees,' and 'clinical programs support.' These are never rebates under the contract language — so a 100% rebate pass-through clause doesn't capture them. The total undisclosed manufacturer revenue flowing to PBMs is estimated at 15–40% of brand drug list price.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

Specialty and brand drugs average 30–50% of drug spend for a mid-size plan. Manufacturer rebates on these drugs average 18–35% of list price (WAC). A plan with $1.5M in brand/specialty drug spend generating 25% in manufacturer rebates = $375,000 in manufacturer payments. A pooled arrangement that captures only 65% of earned rebates leaves $131,250/year on the table. Non-rebate manufacturer payments add another estimated $40,000–$80,000 in unrecaptured revenue.

⚑ RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

"Rebates" means the amounts received by PBM from manufacturers pursuant to formulary positioning agreements, net of PBM's administrative costs

"PBM shall pass through a portion of manufacturer rebates consistent with PBM's pooled rebate methodology"

"PBM retains administrative fees, data fees, and other non-rebate manufacturer payments as compensation for services"

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

Add: "PBM shall pass through 100% of all Manufacturer Revenue earned in connection with the Plan's claims to the Plan, not later than 90 days after the close of each calendar quarter. Manufacturer Revenue means all cash, credits, and other forms of compensation received by PBM from any pharmaceutical manufacturer in connection with Plan claims, including without limitation: (i) base rebates, (ii) market share bonuses, (iii) performance bonuses, (iv) administrative fees, (v) data license fees, (vi) educational grants, and (vii) any other amounts, regardless of how characterized by the manufacturer or PBM."

⊗ Delayed rebate remittance timing

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No remittance deadlines or interest on late payments.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Manufacturer rebates are not just one pool of money — they are a complex ecosystem of payments including per-unit rebates, market share bonuses, performance bonuses, administrative fees, data fees, and 'educational grants.' PBMs negotiate all of these in their own name, collect them from manufacturers, and the contract language that determines what passes through to the plan is almost always favorable to the PBM.

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REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

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MET (4)

- Partial rebate pass-through structures

  > *"Ineligible Claims... and Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."*

- Manufacturer contracting exclusivity control

  > *"Formulary may be developed and approved by the PBM's P&T Committee..."*

- Rebate eligibility ambiguity

  > *"Ineligible Claims... Claims for which a Plan or any of its Affiliates has obtained a direct or indirect price concession; ... 100% Member Paid Program Claims..."*

Off-invoice rebate capture risk

> *"Ineligible Claims... Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."*

GAP SUMMARY

Eligibility carve-outs and lack of 100% all-manufacturer-value pass-through enable PBM to retain significant off-invoice revenue, misaligning formulary incentives.

RECOMMENDED CONTRACT LANGUAGE

```
"PBM shall remit 100% of all Manufacturer Revenue (rebates, admin fees, price protection, inflation, data, guarantees) attributable to Sponsor utilization within 60 days of receipt, with 8% APR interest thereafter; eligibility defined solely by paid claims under Sponsor's plan, regardless of copay assistance or other concessions."
```

NEGOTIATION TALKING POINT

"Request manufacturer-level contracts for top 50 NDCs under NDA, a revenue taxonomy, and prior 12-month class-level ledger showing all monies by type vs. claim IDs; reconcile excluded 'ineligible' claims and quantify withheld value."

SECTION 5 · PROVISION 4 OF 10

Formulary Control

4.0
OUT OF 10

CONCERN 3 of 5 requirements met

WHY THIS PROVISION MATTERS

Claims data is among the most valuable assets of a self-funded plan. Ownership, access, portability, and restrictions on commercial use are distinct rights that must each be explicitly negotiated.

FINANCIAL CONTEXT

PBMs routinely sell de-identified claims data to pharmaceutical companies, hedge funds, and health analytics firms. A self-funded plan's data has commercial value estimated at $15–$50 per member per year. Preventing PBM monetization preserves this value for the plan.

FIDUCIARY SIGNIFICANCE

Real-time data access enables fraud detection, specialty drug management, and clinical intervention — generating additional savings through early identification of high-cost claimants.

ISSUE EVALUATION (5 ISSUES)

⊗ NOT MET — 2 PROTECTIONS MISSING

Step therapy enforcement control

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No clarity on who sets/approves step and PA rules or appeals standards.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Your plan's claims data is one of the most commercially valuable assets you own. Every prescription filled by a plan member contains diagnosis codes, drug names, dosages, prescribers, and patient identifiers — data that pharmaceutical manufacturers, hedge funds, data brokers, and academic institutions pay significant sums to access. Without contractual restrictions, the PBM owns or controls this data and sells it commercially.
2. PBMs typically insert language stating that de-identified data is their proprietary asset and can be used for 'PBM's business purposes.' This language permits the PBM to sell your members' drug utilization patterns to the manufacturers of the drugs they're taking — creating a deeply problematic conflict where the PBM profits from data generated by the plan's own members.
3. Beyond commercialization, lack of data access prevents the plan from conducting independent audits, benchmarking drug costs, identifying high-risk members for care management, or switching PBMs at contract end. PBMs routinely delay, restrict, or charge for data access to create switching costs and reduce plan oversight.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

Commercial value of pharmaceutical claims data is estimated at $15–$50 per member per year for de-identified datasets, and significantly more for linked or longitudinal data. For a 500-member plan, this represents $7,500–$25,000/year in value that the PBM captures from your members' data. Beyond direct commercialization, data access restrictions cost plans an estimated $8–$25 per member in avoidable high-cost drug spend that targeted interventions would have prevented.

RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

```
"De-identified claims data is proprietary to PBM and may be used for PBM's business purposes"
```

"Plan data will be provided in PBM's standard format upon written request within 30 business days"

"PBM shall provide plan performance reports as mutually agreed upon by the parties"

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

> Add: "All claims data, including identifiable and de-identified data, generated in connection with Plan is and remains the exclusive property of Plan. PBM shall not sell, license, share, or otherwise transfer Plan data to any third party without Plan's prior written consent. PBM shall provide Plan with access to all claims data in machine-readable format within 5 business days of request, at no additional charge. Upon contract termination, PBM shall deliver a complete claims history file to Plan's designee within 30 days."

Therapeutic substitution discretion

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No constraints on PBM-driven therapeutic interchange programs.

⚠ HOW PBMS EXPLOIT THIS GAP

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MET (3)

PBM unilateral formulary authority

"For Medicaid and Commercial lines of business, the "Formulary" may be developed and approved by the PBM's P&T Committee and/or the Sponsor's P&T Committee."

Exclusion list opacity

"Formulary... quantity limits, prior authorization guidelines, and clinical guidelines..."

Tiering manipulation incentives

"Formulary may be developed and approved by the PBM's P&T Committee..."

GAP SUMMARY

Ambiguous control permits PBM to optimize rebate economics over net cost through tiering, exclusions, and utilization edits.

RECOMMENDED CONTRACT LANGUAGE

"Sponsor retains final formulary authority; PBM must present net-cost analyses inclusive of all manufacturer revenue; biosimilar-first and lowest-net-cost rules apply. Material changes require 60 days' notice and Sponsor written consent."

NEGOTIATION TALKING POINT

"Demand 12-month change log of formulary actions with net cost modeling by NDC, including foregone rebate vs. acquisition cost; require biosimilar adoption plan with savings projections."

SECTION 6 · PROVISION 5 OF 10

Pharmacy Network Design

4.0
OUT OF 10

CONCERN 4 of 5 requirements met

WHY THIS PROVISION MATTERS

Audit rights are the enforcement mechanism for all financial provisions. An audit clause without retroactive lookback, extrapolation rights, and enforceability is effectively worthless.

FINANCIAL CONTEXT

Industry data shows that PBM audits with full extrapolation rights recover an average of $45–$180 per member per audit cycle. For a 500-life plan, a proper 36-month audit with extrapolation could recover $22,500–$90,000 in overcharges. Without extrapolation, systemic overcharges across thousands of claims are unrecoverable.

FIDUCIARY SIGNIFICANCE

Audit rights are only valuable if the scope, lookback period, methodology, and enforceability are all contractually defined. A limited audit clause without extrapolation provides false security.

ISSUE EVALUATION (5 ISSUES)

⊗ NOT MET — 1 PROTECTION MISSING

Preferred pharmacy steering

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No disclosure on preferred tiers or cost parity requirements.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Most PBM contracts contain audit rights clauses that look protective but are specifically designed to prevent meaningful recovery. Typical restrictions include: limiting audits to a 12-month lookback period (when systematic errors compound over 36+ months), prohibiting statistical extrapolation (meaning each overcharged claim must be individually documented), requiring 90+ days notice (giving the PBM time to prepare defenses), and capping recoveries at nominal amounts.

2. The most damaging restriction is the prohibition on extrapolation. If an audit discovers that the PBM consistently overcharged by $4.20 per claim for metformin across 15,000 fills, the plan should be able to recover the overcharge across all 15,000 fills ($63,000). Without extrapolation rights, the plan can only recover the exact amount for each claim individually documented — a process so expensive and time-consuming that most overcharges go unrecovered.

3. PBMs also insert audit scope limitations that exclude the most valuable areas for recovery: MAC list pricing, manufacturer payments, proprietary pricing schedules, and specialty drug reimbursement are commonly excluded from audit scope, precisely because these are the areas with the greatest discrepancies.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

Industry data shows that PBM audits with full extrapolation rights recover an average of $45–$180 per member per audit cycle. For a 500-member plan, a fully-scoped 36-month audit with extrapolation could recover $22,500–$90,000 in overpayments that without extrapolation would require claim-by-claim documentation costing more than the recovery. The 12-month lookback vs. 36-month lookback restriction alone eliminates two-thirds of potential recovery.

RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

"Audits shall be limited to a 12-month period preceding the audit request"

"Statistical sampling and extrapolation methodologies are not permitted"

"Plan must provide 90 days prior written notice before conducting any audit"

"Audit scope shall not include PBM's proprietary pricing methodologies or MAC schedules"

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

Add: "Plan shall have the right to audit PBM's books, records, and systems related to Plan's account at any time, with 15 days prior written notice. Audits shall cover a 36-month lookback period. Plan's auditor may use statistical sampling with extrapolation to quantify systemic discrepancies. Any overpayments identified shall be refunded to Plan within 30 days, with interest at 8% per annum from the date of overpayment. Audit costs shall be borne by PBM if the audit reveals discrepancies exceeding $10,000."

MET (4)

Differential reimbursement across pharmacies

"PBM's MAC Lists and payment/cost schedules are frequently updated."

Mail-order coercion mechanisms

"Mail Order Pharmacy... contracted with and/or owned or operated by PBM."

Limited pharmacy network transparency

"PBM will provide Sponsor with a copy of the MAC List upon request."

Spread capture via network design

"PBM's MAC Lists and payment/cost schedules are frequently updated."

GAP SUMMARY

Ownership of mail/specialty and unilateral network pricing enable steering to higher-margin channels and spread via differential reimbursement.

RECOMMENDED CONTRACT LANGUAGE

```
"PBM guarantees plan billing equals pharmacy reimbursement by
claim; Sponsor approval required for network tiering; PBM-owned
pharmacies must meet or beat open network best net cost by NDC."
```

NEGOTIATION TALKING POINT

"Request channel-by-channel rate cards and 12-month claims with pharmacy NPI, ingredient, DF, and PBM-owned flag; require side-by-side net cost vs. open network comparators."

SECTION 7 · PROVISION 6 OF 10

Specialty Drug Management

3.5
OUT OF 10

CONCERN 3 of 5 requirements met

WHY THIS PROVISION MATTERS

PBMs that own specialty pharmacies — including Optum Rx (OptumRx Specialty), Express Scripts (Accredo), and CVS Caremark (Specialty Operations) — have documented conflicts of interest in specialty drug dispensing.

FINANCIAL CONTEXT

PBMs that own specialty pharmacies earn additional margin when they direct members to their own dispensing operations. Specialty drugs represent ~50% of drug spend for many plans. Even a 5% differential in specialty drug cost on $1M of specialty spend = $50,000 per year in excess cost.

FIDUCIARY SIGNIFICANCE

Specialty pharmacy is the fastest-growing segment of pharmacy spend. Contractual neutrality requirements and independent oversight are essential to prevent PBM conflict of interest in this space.

ISSUE EVALUATION (5 ISSUES)

⊗ **NOT MET — 2 PROTECTIONS MISSING**

Site-of-care steering restrictions

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No rights for SOC optimization from hospital outpatient to home/ambulatory infusion.

⚠ HOW PBMS EXPLOIT THIS GAP

1. The three largest PBMs — CVS Caremark, OptumRx, and Express Scripts — each own specialty pharmacy operations (CVS Specialty, OptumRx Specialty, Accredo). When a member needs a specialty drug, the PBM has a direct financial incentive to dispense through its own pharmacy rather than an independent pharmacy that may be cheaper. The PBM controls the specialty formulary, the prior authorization process, and the mandatory specialty pharmacy designations in the plan design — all of which it can use to steer volume to its own operation.

2. The excess cost of owned-specialty vs. independent-specialty dispensing averages 8–15% per claim. But the real danger is in pricing opacity: when the PBM is both the price-setter and the dispenser, there is no market check on specialty drug cost. The PBM can set specialty prices at whatever level maximizes its margin, and the plan has no ability to compare or negotiate.

3. Beyond pricing, owned specialty pharmacies create conflict of interest in clinical management. The PBM's specialty pharmacy has an incentive to maximize refills, minimize therapeutic alternatives, and resist biosimilar substitution — all of which increase the plan's drug spend while increasing the PBM's revenue.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

Specialty drugs represent approximately 50% of drug spend for most mid-size plans despite accounting for only 1–2% of prescription volume. For a plan with $1.5M in specialty spend, an 8–15% excess cost due to owned-pharmacy steering represents $120,000–$225,000 per year. An independent specialty pharmacy with competitive pricing and biosimilar protocols typically achieves 10–20% savings vs. PBM-owned specialty, net of any access or coordination costs.

► RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

"Specialty drugs must be dispensed by PBM's designated specialty pharmacy or an approved specialty pharmacy network"

"Members may use any specialty pharmacy in PBM's specialty network, subject to applicable cost-sharing"

"PBM's specialty pharmacy is the preferred dispenser for specialty medications"

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

Add: "PBM shall not mandate or prefer its affiliated or owned specialty pharmacies over independent specialty pharmacies. Plan shall retain the right to designate any accredited specialty pharmacy as the preferred or exclusive specialty pharmacy for Plan members. PBM shall apply identical prior authorization criteria, clinical protocols, and cost-sharing structures to all accredited specialty pharmacies regardless of PBM affiliation. PBM shall provide Plan with quarterly specialty pharmacy pricing comparisons against independent market benchmarks."

White/brown bagging mandates

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No guardrails; PBM can mandate bagging via owned specialty without price parity or clinical exception path.

HOW PBMS EXPLOIT THIS GAP

1. The three largest PBMs — CVS Caremark, OptumRx, and Express Scripts — each own specialty pharmacy operations (CVS Specialty, OptumRx Specialty, Accredo). When a member needs a specialty drug, the PBM has a direct financial incentive to dispense through its own pharmacy rather than an independent pharmacy that may be cheaper. The PBM controls the specialty formulary, the prior authorization process, and the mandatory specialty pharmacy designations in the plan design — all of which it can use to steer volume to its own operation.

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MET (3)

Specialty carve-out opacity

"Limited Distribution Drug... dispensing is restricted by the pharmaceutical manufacturer to only 3 or fewer pharmacies."

High-cost drug reimbursement manipulation

"Biosimilar Drugs are Brand Drugs, unless... required to be classified as Generic..."

Specialty rebate separation from plan sponsor

"Ineligible Claims... Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."

GAP SUMMARY

Specialty class definitions and LDD constructs without pricing and rebate guardrails enable elevated net cost and PBM margin capture.

RECOMMENDED CONTRACT LANGUAGE

```
"Specialty pricing caps: non-LDD AWP-22% max, LDD AWP-17% max;
biosimilar-first with parity tiering; 100% pass-through of all
specialty manufacturer revenue; SOC optimization program with
target savings and provider contracting rights."
```

NEGOTIATION TALKING POINT

"Provide top-50 specialty NDCs with net cost after all manufacturer revenue; identify LDD vs. non-LDD and channel; deliver biosimilar adoption gap analysis with savings opportunity."

SECTION 8 · PROVISION 7 OF 10

Audit Rights & Recovery

2.0
OUT OF 10

RED FLAG 0 of 5 requirements met

WHY THIS PROVISION MATTERS

Carve-out rights preserve plan optionality. Without them, the PBM contractually locks the plan into a single vendor for specialty drugs — preventing competition and benchmarking.

FINANCIAL CONTEXT

Plans that can carve out specialty drugs to independent dispensers typically save 10–25% on specialty spend. Without contractual carve-out rights, the PBM can contractually block the plan from using lower-cost alternatives. For a plan with $500K in specialty spend, this represents $50K–$125K per year.

FIDUCIARY SIGNIFICANCE

The ability to benchmark and carve out is the single most powerful leverage tool in PBM negotiations. Contracts that restrict this right permanently disadvantage the plan.

ISSUE EVALUATION (5 ISSUES)

⊗ NOT MET — 5 PROTECTIONS MISSING

⊗ Limited audit scope clauses

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No affirmative audit scope defined; risk PBM restricts to summary reports.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Specialty drug carve-out means the plan can direct specialty prescription claims to a different vendor than the PBM — typically an independent specialty pharmacy, a GPO, or a direct manufacturer program. Without carve-out rights, the PBM owns all specialty volume, and the plan cannot take advantage of competitive pricing, manufacturer copay assistance programs, or direct-to-employer specialty programs that routinely save 15–30% over PBM-bundled specialty pricing.

2. PBMs insert anti-carve-out clauses because specialty pharmacy is their fastest-growing profit center. Common anti-carve-out tactics include: (1) tying specialty carve-out to termination clauses that require 180+ days notice, (2) requiring minimum annual specialty volume commitments that make carve-out economically infeasible, (3) reducing rebate pass-through rates if specialty is carved out, effectively penalizing the plan for using the carve-out right.

3. The practical result: even when the plan has nominal carve-out rights, the economic structure makes them impossible to exercise. This is contractual lock-in disguised as flexibility.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

Independent specialty pharmacy programs and direct manufacturer arrangements routinely save 12–28% vs. PBM-bundled specialty pricing. For a plan with $1.5M in specialty spend, this represents $180,000–$420,000 in annual savings opportunity. Even conservative access to biosimilar-first specialty programs (which PBM-owned pharmacies routinely resist) saves an additional 5–15% on applicable high-cost biologics.

⚑ RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

```
"Specialty carve-out requires 180 days prior written notice and is subject to PBM approval"
```

"Rebate pass-through rates shall be reduced by 40% if Plan elects to carve out specialty pharmacy"

"Plan must maintain minimum annual specialty claim volume of $X to access specialty pricing"

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

> Add: "Plan retains the unconditional right to carve out specialty pharmacy dispensing to any accredited specialty pharmacy or program of Plan's choice, exercisable upon 30 days written notice, without penalty, reduction in rebate pass-through, or reduction in any other contracted benefit. PBM shall cooperate with any designated specialty pharmacy to ensure seamless claims processing, clinical coordination, and data sharing."

⊗ Short audit lookback windows

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

Lookback not stated; PBM can limit to 6-12 months.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Specialty drug carve-out means the plan can direct specialty prescription claims to a different vendor than the PBM — typically an independent specialty pharmacy, a GPO, or a direct manufacturer program. Without carve-out rights, the PBM owns all specialty volume, and the plan cannot take advantage of competitive pricing, manufacturer copay assistance programs, or direct-to-employer specialty programs that routinely save 15–30% over PBM-bundled specialty pricing.
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⊗ Data access restrictions during audit

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No right to de-identified claim-level and contract/manufacturer documentation.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Specialty drug carve-out means the plan can direct specialty prescription claims to a different vendor than the PBM — typically an independent specialty pharmacy, a GPO, or a direct manufacturer program. Without carve-out rights, the PBM owns all specialty volume, and the plan cannot take advantage of competitive pricing, manufacturer copay assistance programs, or direct-to-employer specialty programs that routinely save 15–30% over PBM-bundled specialty pricing.

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Recovery limitations post-audit

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No interest on recoveries or mandatory timing.

⚠ HOW PBMS EXPLOIT THIS GAP

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PBM-controlled audit methodology

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No sponsor right to select auditor or define sampling.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Specialty drug carve-out means the plan can direct specialty prescription claims to a different vendor than the PBM — typically an independent specialty pharmacy, a GPO, or a direct manufacturer program. Without carve-out rights, the PBM owns all specialty volume, and the plan cannot take advantage of competitive pricing, manufacturer copay assistance programs, or direct-to-employer specialty programs that routinely save 15–30% over PBM-bundled specialty pricing.

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GAP SUMMARY

Absence of strong audit rights preserves PBM's information advantage and limits recovery of overpayments and withheld manufacturer value.

RECOMMENDED CONTRACT LANGUAGE

"Sponsor may audit all financial and operational records, including claim-level data and manufacturer agreements under NDA, for a rolling 36-month period; PBM funds reasonable audit costs if variance >1%; all recoveries plus 8% APR interest due within 30 days."

NEGOTIATION TALKING POINT

"Require full data extract (claims, pricing, rebates) prior to renewal; propose independent auditor and pre-agree on sampling and variance thresholds."

SECTION 9 · PROVISION 8 OF 10

Transparency & Disclosure

3.0
OUT OF 10

RED FLAG 3 of 5 requirements met

WHY THIS PROVISION MATTERS

The 'lowest net cost' standard — net of rebates and all other manufacturer payments — is the gold standard for formulary management. It ensures clinical decisions are made on evidence, not economics.

FINANCIAL CONTEXT

When PBMs are not obligated to dispense the lowest net cost option at point of sale, they may dispense brand drugs with high rebates while collecting plan cost-sharing based on higher AWP prices — generating revenue while costing the plan more. Formulary optimization and biosimilar substitution can reduce brand drug spend by 8–20%.

FIDUCIARY SIGNIFICANCE

Clinical integrity means formulary decisions are made on evidence-based criteria, not economic incentives. Without this contractual commitment, PBMs can legally favor high-margin drugs.

ISSUE EVALUATION (5 ISSUES)

⊗ NOT MET — 2 PROTECTIONS MISSING

⊗ Lack of ingredient cost disclosure

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No claim-level pharmacy paid ingredient and DF disclosure to sponsor.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Without a 'lowest net cost' formulary management requirement, the PBM can legally prefer drugs on its formulary based on manufacturer payments rather than clinical efficacy or cost to the plan. The classic example: a brand drug with a high list price ($800/month) and a 40% manufacturer rebate costs the plan $480/month net. A generic equivalent with no rebate costs $28/month. The PBM has an economic incentive to keep the brand drug on formulary — even though the plan pays $452 more per fill. Without this clause, they can do this legally.

2. Biosimilar substitution is the most glaring current example. Brand biologics (Humira, Enbrel, Stelara) have lost patent protection and biosimilar alternatives are available at 30–80% discounts. PBMs that own specialty pharmacies and receive large brand manufacturer rebates have actively resisted biosimilar substitution. Plans without 'lowest net cost' and biosimilar-first formulary requirements are paying brand prices for drugs that have cheaper, clinically equivalent alternatives today.

3. Step therapy protocols, prior authorization criteria, and formulary tier placement are all tools the PBM can use to advantage high-rebate drugs. Without clinical integrity requirements, the PBM's formulary is a revenue-maximization tool masquerading as clinical management.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

The gap between highest-rebate formulary management and lowest-net-cost formulary management averages 6–14% of total drug spend. For a $3M drug spend plan, this is $180,000–$420,000/year. Biosimilar conversion alone — switching applicable members from Humira to adalimumab biosimilars — saves $25,000–$150,000/year for plans with 5–20 Humira users, at identical clinical outcomes.

⚑ RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

"PBM shall maintain clinically appropriate formulary and utilization

management protocols"

"Formulary composition is determined by PBM's pharmacy and therapeutics committee in its sole discretion"

"PBM shall consider clinical evidence and cost-effectiveness in formulary management decisions"

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

> Add: "PBM shall manage the Plan's formulary on a lowest net cost basis, defined as the lowest total cost to the Plan net of all manufacturer payments associated with each drug. For any drug with one or more biosimilar equivalents approved by FDA as interchangeable, PBM shall place biosimilars in the lowest cost tier and shall apply step therapy protocols favoring biosimilar initiation over brand biologic initiation, unless medically contraindicated for a specific member."

Non-itemized claim-level visibility

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No commitment to provide full NCPDP fields necessary to reconcile pricing and rebates.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Without a 'lowest net cost' formulary management requirement, the PBM can legally prefer drugs on its formulary based on manufacturer payments rather than clinical efficacy or cost to the plan. The classic example: a brand drug with a high list price ($800/month) and a 40% manufacturer rebate costs the plan $480/month net. A generic equivalent with no rebate costs $28/month. The PBM has an economic incentive to keep the brand drug on formulary — even though the plan pays $452 more per fill. Without this clause, they can do this legally.

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MET (3)

- "Proprietary information" shielding used to block pricing disclosure

  > *"PBM will provide Sponsor with a copy of the MAC List upon request."*

- Black box rebate reporting

  > *"Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."*

- Aggregate-only reporting structures

  > *"PBM will provide... MAC List upon request."*

GAP SUMMARY

On-request and summary-level disclosures maintain opacity around the key money flows (MAC, ingredient cost, rebates).

RECOMMENDED CONTRACT LANGUAGE

"PBM will provide monthly claim-level files including all NCPDP fields, pharmacy paid components, plan paid, member cost share, MAC identifiers, and all manufacturer revenue attribution by claim; no proprietary redactions."

NEGOTIATION TALKING POINT

"Request a data spec and sample feed; include a data-rights rider guaranteeing unrestricted use for audit and optimization."

SECTION 10 · PROVISION 9 OF 10

Performance Guarantees

2.5
OUT OF 10

RED FLAG 0 of 4 requirements met

WHY THIS PROVISION MATTERS

Termination rights determine whether all other contract protections are real or theoretical. A plan that cannot exit cannot enforce its rights. Termination notice, data return, and exit penalty clauses must be plan-favorable.

FINANCIAL CONTEXT

Long notice periods (90–180 days) and termination fees lock plans into unfavorable arrangements, preventing timely corrective action after identifying overcharges or underperformance. Plans that cannot exit quickly pay an estimated $1,200–$4,500 per member per year in excess costs during the lock-in period.

FIDUCIARY SIGNIFICANCE

A clean exit clause is the enforcement mechanism for all other contract provisions. Without it, the plan has no practical remedy for PBM noncompliance during the contract term.

ISSUE EVALUATION (4 ISSUES)

⊗ NOT MET — 4 PROTECTIONS MISSING

⊗ Weak or non-binding performance quality levels (PQLs)

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No PQLs stated (call center, turnaround times, prior auth SLAs).

⚠ HOW PBMS EXPLOIT THIS GAP

1. A termination clause determines whether your plan can actually escape a bad PBM contract. PBMs insert long notice periods (90–180 days), high termination fees, data withholding provisions, and 'cure period' requirements that make early termination practically impossible. The result: even after discovering that the PBM has been overcharging you for three years, you cannot exit quickly enough to stop the bleeding.

2. Termination fees are often disguised as 'wind-down costs,' 'implementation fee amortization,' or 'technology migration costs.' These fees are rarely disclosed at contract signing and can run to $50,000–$250,000 for a mid-size plan — effectively making it economically impossible to switch PBMs even when switching would save far more.

3. Data withholding is the most insidious termination tactic. Many contracts allow the PBM to delay delivering historical claims data for 30–90 days after termination. Without this data, the plan cannot onboard a new PBM efficiently, cannot conduct a retroactive audit of the exiting PBM, and cannot provide continuity of care documentation. The 'data hostage' tactic gives the PBM enormous leverage in termination disputes.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

A 180-day termination notice requirement vs. a 30-day requirement means a plan that discovers systematic PBM overcharging in January continues paying the PBM for 6 additional months before transitioning. If the overcharge rate is $30,000/month, the extra 5 months of notice costs $150,000. Termination fees on top of this ($50,000–$250,000) make the practical cost of switching from a bad PBM contract $200,000–$400,000 in sunk costs.

⚑ RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

```
"Either party may terminate this Agreement upon 180 days prior written notice"
```

"Upon termination, Plan shall pay PBM's reasonable wind-down costs, including technology migration and implementation amortization"

"PBM shall deliver historical claims data within 90 days of the effective date of termination"

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

> Add: "Either party may terminate this Agreement without cause upon 30 days prior written notice, or for cause (including material breach, loss of license, or insolvency) immediately upon written notice. Upon termination: (i) no termination or wind-down fees shall be payable by Plan; (ii) PBM shall deliver complete claims data to Plan's designee within 5 business days; (iii) PBM shall cooperate fully with Plan's successor PBM. This Agreement contains no minimum volume commitments or lock-in provisions."

Utilization threshold manipulation

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No guarantee definitions for generic dispensing rate, formulary compliance, biosimilar uptake.

⚠ HOW PBMS EXPLOIT THIS GAP

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⊗ Bonus-driven misalignment incentives

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No alignment of PBM bonuses to sponsor net cost.

⚠ HOW PBMS EXPLOIT THIS GAP

1. A termination clause determines whether your plan can actually escape a bad PBM contract. PBMs insert long notice periods (90–180 days), high termination fees, data withholding provisions, and 'cure period' requirements that make early termination practically impossible. The result: even after discovering that the PBM has been overcharging you for three years, you cannot exit quickly enough to stop the bleeding.

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Penalty avoidance loopholes

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No liquidated damages or dollar-at-risk tied to measurable outcomes.

⚠ HOW PBMS EXPLOIT THIS GAP

1. A termination clause determines whether your plan can actually escape a bad PBM contract. PBMs insert long notice periods (90–180 days), high termination fees, data withholding provisions, and 'cure period' requirements that make early termination practically impossible. The result: even after discovering that the PBM has been overcharging you for three years, you cannot exit quickly enough to stop the bleeding.

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GAP SUMMARY

No outcomes-based guarantees tied to net cost, biosimilar adoption, or service SLAs.

RECOMMENDED CONTRACT LANGUAGE

"At least 10% of PBM admin fees at risk against net cost PMPM targets, biosimilar adoption >85% where available, GDR targets by class, and service SLAs; shortfall credited quarterly."

NEGOTIATION TALKING POINT

"Propose a value scorecard with quarterly settlement and transparent methodology; require claim-level backing data."

SECTION 11 · PROVISION 10 OF 10

Termination & Exit Barriers

3.0
OUT OF 10

RED FLAG 0 of 4 requirements met

WHY THIS PROVISION MATTERS

Administrative fees should be itemized, benchmarked, and subject to performance guarantees with at-risk dollars. PMPM fees, claim fees, specialty fees, and clinical program fees all require transparency.

FINANCIAL CONTEXT

Administrative fees vary enormously — from $1.50 to $8.00 PMPM for identical services. Without fee benchmarking rights and performance guarantees, plans cannot verify market competitiveness. SLA-backed performance guarantees with financial penalties create alignment between PBM compensation and plan outcomes.

FIDUCIARY SIGNIFICANCE

Performance guarantees without financial consequences are marketing — not enforceable obligations. Guarantees should be backed by at-risk dollars equal to 5–10% of total PBM compensation.

ISSUE EVALUATION (4 ISSUES)

⊗ NOT MET — 4 PROTECTIONS MISSING

Early termination penalties

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No termination rights/penalties listed; risk of punitive fees.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Administrative fee structures are among the most opaque elements of PBM contracts. Plans are quoted a headline PMPM rate, but the actual administrative cost is composed of many separate line items — claim processing fees, specialty fees, clinical program fees, prior authorization fees, formulary management fees, reporting fees — that are never fully itemized at contract signing. The total true administrative cost is typically 30–60% higher than the headline PMPM rate.

2. Performance guarantees are the most commonly abused element of PBM contracts. PBMs offer guarantees that sound meaningful — 'generic dispensing rate above 85%,' '90-day refill rates above 78%' — but are structured with loopholes that prevent recovery: (1) metrics are self-reported by the PBM, (2) cure periods allow the PBM to fix performance after the plan discovers a breach, (3) total at-risk dollars are capped at 2–5% of administrative fees (a few thousand dollars), (4) measurement periods are designed to average away quarterly underperformance.

3. The absence of benchmarking rights means the plan cannot determine whether its administrative fees are competitive. PBM administrative fees vary by 200–400% for identical service levels across different clients — and without market benchmarking rights, a plan paying $6 PMPM for services worth $2 PMPM has no contractual recourse.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

Administrative fee overcharges for a 500-member plan average $80,000–$180,000/year when benchmarked against market rates. Performance guarantees with 2–5% at-risk vs. 10–15% at-risk represent an accountability gap of $20,000–$40,000/year in unenforceable commitments. Fee benchmarking rights typically identify 20–35% administrative fee reduction opportunities for plans that haven't negotiated in 2+ years.

► RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

"Administrative fees are set forth in Exhibit A and are subject to annual adjustment at PBM's discretion"

"Performance guarantees are subject to a 90-day cure period before any penalty applies"

"Total performance guarantee at-risk amount shall not exceed 3% of annual administrative fees"

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

Add: "PBM shall provide Plan with an itemized fee schedule disclosing all components of administrative compensation. Plan shall have the right to benchmark administrative fees against market rates annually and to negotiate adjustments if fees exceed the 60th percentile of market rates for comparable plans. Performance guarantees shall have no less than 10% of total annual PBM compensation at risk, measured quarterly, self-cure periods shall not exceed 30 days, and shall be based on independently verifiable data."

Data export restrictions upon exit

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No obligation to provide complete historical data in standard formats.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Administrative fee structures are among the most opaque elements of PBM contracts. Plans are quoted a headline PMPM rate, but the actual administrative cost is composed of many separate line items — claim processing fees, specialty fees, clinical program fees, prior authorization fees, formulary management fees, reporting fees — that are never fully itemized at contract signing. The total true administrative cost is typically 30–60% higher than the headline PMPM rate.

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► RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

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"Performance guarantees are subject to a 90-day cure period before any penalty applies"

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REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

Add: "PBM shall provide Plan with an itemized fee schedule disclosing all components of administrative compensation. Plan shall have the right to benchmark administrative fees against market rates annually and to negotiate adjustments if fees exceed the 60th percentile of market rates for comparable plans. Performance guarantees shall have no less than 10% of total annual PBM compensation at risk, measured quarterly, self-cure periods shall not exceed 30 days, and shall be based on independently verifiable data."

Contract lock-in renewal structures

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No auto-renewal notice windows specified.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Administrative fee structures are among the most opaque elements of PBM contracts. Plans are quoted a headline PMPM rate, but the actual administrative cost is composed of many separate line items — claim processing fees, specialty fees, clinical program fees, prior authorization fees, formulary management fees, reporting fees — that are never fully itemized at contract signing. The total true administrative cost is typically 30–60% higher than the headline PMPM rate.

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► RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

"Administrative fees are set forth in Exhibit A and are subject to annual adjustment at PBM's discretion"

"Performance guarantees are subject to a 90-day cure period before any penalty applies"

"Total performance guarantee at-risk amount shall not exceed 3% of annual administrative fees"

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

Add: "PBM shall provide Plan with an itemized fee schedule disclosing all components of administrative compensation. Plan shall have the right to benchmark administrative fees against market rates annually and to negotiate adjustments if fees exceed the 60th percentile of market rates for comparable plans. Performance guarantees shall have no less than 10% of total annual PBM compensation at risk, measured quarterly, self-cure periods shall not exceed 30 days, and shall be based on independently verifiable data."

Financial penalties for switching PBMs

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No penalty language visible; risk remains.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Administrative fee structures are among the most opaque elements of PBM contracts. Plans are quoted a headline PMPM rate, but the actual administrative cost is composed of many separate line items — claim processing fees, specialty fees, clinical program fees, prior authorization fees, formulary management fees, reporting fees — that are never fully itemized at contract signing. The total true administrative cost is typically 30–60% higher than the headline PMPM rate.

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► RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

"Administrative fees are set forth in Exhibit A and are subject to annual adjustment at PBM's discretion"

"Performance guarantees are subject to a 90-day cure period before any penalty applies"

"Total performance guarantee at-risk amount shall not exceed 3% of annual administrative fees"

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

> Add: "PBM shall provide Plan with an itemized fee schedule disclosing all components of administrative compensation. Plan shall have the right to benchmark administrative fees against market rates annually and to negotiate adjustments if fees exceed the 60th percentile of market rates for comparable plans. Performance guarantees shall have no less than 10% of total annual PBM compensation at risk, measured quarterly, self-cure periods shall not exceed 30 days, and shall be based on independently verifiable data."

GAP SUMMARY

Potential lock-in through exit fees and data friction diminishes competitive discipline.

RECOMMENDED CONTRACT LANGUAGE

"Sponsor may terminate for convenience with 90 days' notice without penalty; PBM to deliver full 36-month data export at no cost within 15 days of termination."

NEGOTIATION TALKING POINT

"Insist on penalty-free termination-for-convenience and pre-baked data transition package; quantify switching savings to counter any proposed fees."

SECTION 12 · PROVISION 11 OF 10

Claim Adjudication Logic

4.5
OUT OF 10

CONCERN 2 of 5 requirements met

WHY THIS PROVISION MATTERS

Step therapy and prior authorization protocols should reflect independent clinical evidence — not manufacturer rebate economics. Plans must retain override authority and a defined appeal timeline to prevent medically inappropriate denials and protect member access.

FINANCIAL CONTEXT

PBMs profit when plans use high-rebate brand drugs. Step therapy and prior authorization are the primary tools for directing utilization toward those drugs. Without independent clinical oversight and plan override authority, step therapy protocols legally serve PBM economic interests — not plan clinical interests. A plan that cannot override an inappropriate step therapy requirement is locked into the PBM's preferred drug — and its preferred margin.

FIDUCIARY SIGNIFICANCE

CAA 2026 requires meaningful access standards for step therapy appeals. Plans that cannot override medically inappropriate step therapy requirements are exposed to benefits denial litigation and regulatory enforcement.

ISSUE EVALUATION (5 ISSUES)

⊗ NOT MET — 3 PROTECTIONS MISSING

Retroactive claim adjustment authority

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No limits on backdated adjustments.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Step therapy protocols — which require members to try less expensive drugs before 'stepping up' to a more expensive brand — are clinically sound in theory. In practice, PBMs design step therapy criteria to favor drugs with the highest manufacturer rebates rather than the lowest net cost to the plan. A member needing a biologic may be required to fail on a high-rebate brand biologic before being allowed access to a lower-cost biosimilar — the reverse of what serves the plan's financial interest.

2. Prior authorization (PA) criteria are the second major tool. PBMs set PA thresholds that create administrative friction for generic or biosimilar drugs while making high-rebate brand drugs easy to access. The PA process itself — which the PBM controls — can be used to steer prescribers and members toward the PBM's formulary preferred brands regardless of clinical equivalence.

3. When a plan sponsor or member needs a step therapy exception — for example, a patient who has a documented contraindication to the step drug — most PBM contracts require the plan to go through the PBM's internal appeal process, which the PBM controls, has no binding timeline, and can deny for economic reasons. Without a contractual plan override right with a defined 72-hour response window, clinically urgent exceptions are held hostage to the PBM's review process.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

Evidence-based step therapy that genuinely prioritizes lowest net cost vs. highest-rebate step therapy typically produces a 6–14% difference in brand drug spend. For a plan with $1M in brand and specialty drug spend, PBM-designed step therapy protocols that favor high-rebate drugs over clinically equivalent lower-cost options cost the plan $60,000–$140,000 per year in avoidable brand drug spend. Biosimilar step therapy alone — requiring biosimilar trial before brand biologic initiation — saves $20,000–$100,000/year for plans with 5–15 members on brand biologics.

RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

"Step therapy protocols are determined by PBM's pharmacy and therapeutics committee in its clinical discretion"

"Prior authorization criteria are subject to PBM's proprietary clinical guidelines and are not subject to Plan modification"

"Step therapy exceptions require PBM's written approval and are subject to a 14-business-day review period"

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

Add: "Step therapy protocols shall be designed to achieve the lowest net cost formulary management consistent with evidence-based clinical guidelines, not to maximize manufacturer rebate revenue. Plan sponsor retains the right to override any step therapy determination within 72 hours of written notice for clinical urgency. Prior authorization criteria shall be disclosed to the Plan in writing and shall not be modified without 60 days advance notice. PBM shall not use step therapy or prior authorization protocols to advantage high-rebate brand drugs over lower-cost therapeutically equivalent alternatives."

Reversal discretion without notice

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No sponsor notice/approval for reversals.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Step therapy protocols — which require members to try less expensive drugs before 'stepping up' to a more expensive brand — are clinically sound in theory. In practice, PBMs design step therapy criteria to favor drugs with the highest manufacturer rebates rather than the lowest net cost to the plan. A member needing a biologic may be required to fail on a high-rebate brand biologic before being allowed access to a lower-cost biosimilar — the reverse of what serves the plan's financial interest.

2. Prior authorization (PA) criteria are the second major tool. PBMs set PA thresholds that create administrative friction for generic or biosimilar drugs while making high-rebate brand drugs easy to access. The PA process itself — which the PBM controls — can be used to steer prescribers and members toward the PBM's formulary preferred brands regardless of clinical equivalence.

3. When a plan sponsor or member needs a step therapy exception — for example, a patient who has a documented contraindication to the step drug — most PBM contracts require the plan to go through the PBM's internal appeal process, which the PBM controls, has no binding timeline, and can deny for economic reasons. Without a contractual plan override right with a defined 72-hour response window, clinically urgent exceptions are held hostage to the PBM's review process.

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Claim reprocessing opacity

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No obligation to disclose reprocessed claims and impact.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Step therapy protocols — which require members to try less expensive drugs before 'stepping up' to a more expensive brand — are clinically sound in theory. In practice, PBMs design step therapy criteria to favor drugs with the highest manufacturer rebates rather than the lowest net cost to the plan. A member needing a biologic may be required to fail on a high-rebate brand biologic before being allowed access to a lower-cost biosimilar — the reverse of what serves the plan's financial interest.

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REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

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MET (2)

Pricing recalculation ambiguity

> *"PBM's MAC Lists and payment/cost schedules are frequently updated."*

Compound pricing transparency

> *"Compound Drugs shall be priced using the NCPDP D.0 standard which shall capture each ingredient used in the medication."*

GAP SUMMARY

Dynamic MAC updates and absent reprocessing disclosures allow PBM to alter paid amounts post-adjudication without sponsor visibility.

RECOMMENDED CONTRACT LANGUAGE

```
"Pricing files (AWP/MAC) locked at time of adjudication; any post-pay adjustments require prior Sponsor notice and approval; monthly reprocessing report with claim IDs, before/after amounts."
```

NEGOTIATION TALKING POINT

"Request a 12-month reprocessing ledger; implement a 7-day price freeze window and variance thresholds requiring Sponsor sign-off."

SECTION 13 · PROVISION 12 OF 10

Fiduciary & Legal Protections

2.0
OUT OF 10

RED FLAG 1 of 4 requirements met

WHY THIS PROVISION MATTERS

Mail order and specialty drug dispensing are the two highest-margin segments for PBM-owned pharmacy operations. Contractual freedom of dispensing choice and anti-steering protections are essential to prevent the PBM from capturing excess margin on the plan's highest-cost drugs.

FINANCIAL CONTEXT

Mail order pharmacy is the PBM's most profitable dispensing channel. PBMs that own mail order facilities (CVS Mail, OptumRx Home Delivery, Express Scripts Mail Pharmacy) capture the full dispensing margin when members use mandatory mail order programs. The excess cost vs. competitive mail order benchmarks averages 8–18% per fill. For a plan with significant mail order volume, mandatory mail routing to PBM-owned facilities costs $50K–$200K per year in excess dispensing fees alone.

FIDUCIARY SIGNIFICANCE

Mail order mandates are contractual lock-in mechanisms. Plans cannot benefit from competitive pricing from independent mail pharmacies without contractual freedom of dispensing choice.

ISSUE EVALUATION (4 ISSUES)

⊗ **NOT MET — 3 PROTECTIONS MISSING**

⊗ Explicit fiduciary duty disclaimers

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No fiduciary duty acceptance to act in Sponsor's best interest.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Mandatory mail order programs are among the most profitable arrangements for PBM-owned dispensing operations. When the PBM mandates 90-day mail order fills for maintenance drugs (hypertension, diabetes, cholesterol), and routes those fills to its own mail pharmacy, it captures the entire dispensing margin — typically $25–$75 per 90-day fill — while simultaneously eliminating the competitive pressure that retail pharmacy creates. CVS Mail, OptumRx Home Delivery, and Express Scripts Home Delivery collectively process tens of billions of dollars in mail order volume annually.

2. The cost differential between PBM-owned mail order pharmacies and competitive independent mail order options averages 8–18% per fill. For a plan with $800K in maintenance drug mail order volume, mandatory routing to PBM-owned mail facilities costs $64,000–$144,000/year in excess dispensing costs vs. what a competitive mail provider would charge for identical service.

3. Specialty drug steering to PBM-owned specialty pharmacies (Accredo, CVS Specialty, OptumRx Specialty) compounds this problem in the highest-cost drug category. Specialty drugs average $3,000–$15,000 per fill. A 6–12% excess cost on even $500K of specialty volume = $30,000–$60,000/year in excess cost per plan. And because the PBM controls the specialty formulary, prior authorization, and dispensing decision simultaneously, the conflict of interest is structural and invisible without contractual neutrality requirements.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

Mail order arbitrage — the excess cost of PBM-owned mail dispensing vs. competitive market rates — averages $18–$45 per 90-day fill. For a 500-member plan with 200 members on maintenance medications (at 4 fills/year each), annual excess cost from mandatory PBM-owned mail order ranges from $14,400 to $36,000. Specialty drug steering adds an additional $30,000–$120,000/year depending on specialty drug burden.

Combined, mandatory mail and specialty steering cost the typical mid-size plan $45,000–$150,000 annually in excess dispensing margin captured by the PBM.

RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

```
"Members obtaining maintenance drugs shall use PBM's mail order pharmacy for fills of 90 days or greater"
```

```
"Specialty drugs must be dispensed by PBM's designated specialty pharmacy or network specialty pharmacy"
```

```
"Plan members may elect retail dispensing for maintenance drugs subject to an additional cost-sharing differential of 25%"
```

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

> Add: "PBM shall not mandate use of PBM-affiliated or owned mail order or specialty pharmacy for any drug category without Plan's express written consent. Plan members shall retain the right to fill all prescriptions at any accredited retail or mail order pharmacy in the network at identical cost-sharing, regardless of PBM affiliate status. PBM shall provide Plan with quarterly cost-comparison reports benchmarking PBM-owned dispensing costs against three independent mail order and specialty pharmacy alternatives."

Indemnification asymmetry favoring PBM

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No mutual indemnity terms provided.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Mandatory mail order programs are among the most profitable arrangements for PBM-owned dispensing operations. When the PBM mandates 90-day mail order fills for maintenance drugs (hypertension, diabetes, cholesterol), and routes those fills to its own mail pharmacy, it captures the entire dispensing margin — typically $25–$75 per 90-day fill — while simultaneously eliminating the competitive pressure that retail pharmacy creates. CVS Mail, OptumRx Home Delivery, and Express Scripts Home Delivery collectively process tens of billions of dollars in mail order volume annually.

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Liability limitation clauses

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No caps or carve-outs reviewed; risk of low caps limiting recovery.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Mandatory mail order programs are among the most profitable arrangements for PBM-owned dispensing operations. When the PBM mandates 90-day mail order fills for maintenance drugs (hypertension, diabetes, cholesterol), and routes those fills to its own mail pharmacy, it captures the entire dispensing margin — typically $25–$75 per 90-day fill — while simultaneously eliminating the competitive pressure that retail pharmacy creates. CVS Mail, OptumRx Home Delivery, and Express Scripts Home Delivery collectively process tens of billions of dollars in mail order volume annually.

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REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

> Add: "PBM shall not mandate use of PBM-affiliated or owned mail order or specialty pharmacy for any drug category without Plan's express written consent. Plan members shall retain the right to fill all prescriptions at any accredited retail or mail order pharmacy in the network at identical cost-sharing, regardless of PBM affiliate status. PBM shall provide Plan with quarterly cost-comparison reports benchmarking PBM-owned dispensing costs against three independent mail order and specialty pharmacy alternatives."

MET (1)

Conflict-of-interest non-disclosure

> *"Mail Order Pharmacy... owned or operated by PBM."*

GAP SUMMARY

Absence of fiduciary duty and conflict disclosures permits the PBM to prioritize self-interest (owned channels, rebate retention) over Sponsor net cost.

RECOMMENDED CONTRACT LANGUAGE

"PBM acknowledges fiduciary duty to act in Sponsor’s best interest regarding cost management; PBM discloses all ownership/affiliate relationships and associated revenue; conflicts managed via Sponsor consent and lowest-net-cost standard."

NEGOTIATION TALKING POINT

"Require a fiduciary rider and conflict register with revenue categories; tie breaches to fee-at-risk and termination-for-cause."

SECTION 14 · PROVISION 13 OF 10

Data Ownership & Access Rights

2.5
OUT OF 10

RED FLAG 1 of 3 requirements met

WHY THIS PROVISION MATTERS

Performance guarantees are only as strong as the financial penalty backing them. GDR guarantees, formulary compliance rates, claims accuracy, and SLA metrics must each be backed by at-risk dollars, independently verifiable data, and retroactive reconciliation with no self-cure loopholes.

FINANCIAL CONTEXT

Generic dispensing rate (GDR) guarantees are the most commonly breached PBM performance commitment. A PBM that guarantees 85% GDR but delivers 82% across a plan's claims creates measurable excess cost — each 1% GDR miss represents approximately $8–$18 PMPM in brand drug overpayment. Without financial penalties and independent verification, the PBM has no economic incentive to meet its stated GDR targets.

FIDUCIARY SIGNIFICANCE

Annual performance reconciliation with retroactive financial adjustments is the mechanism that makes all performance guarantees enforceable. Without it, guarantees are aspirational benchmarks — not contractual obligations.

ISSUE EVALUATION (3 ISSUES)

⊗ NOT MET — 2 PROTECTIONS MISSING

PBM ownership of claims data

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No explicit Sponsor ownership rights.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Performance guarantee structures in PBM contracts are masterworks of apparent accountability with real-world unenforceability. The typical contract offers guarantees on generic dispensing rate (GDR), formulary compliance, claim processing accuracy, and member satisfaction — all of which sound meaningful and measurable. The exploitation is in the structure: guarantees are self-reported by the PBM using its own data systems, measurement methodology is defined by the PBM, cure periods allow the PBM to 'fix' performance after a breach is identified, and the total at-risk dollar amount is a fraction of actual PBM compensation.

2. The most common structural problem is at-risk dollar caps. A PBM charging $2.50 PMPM administrative fee to a 500-member plan earns $15,000/year in administrative revenue. A performance guarantee with 3% at-risk = $450. When the GDR misses the target for six months, costing the plan $30,000 in avoidable brand drug spend, the maximum recovery is $450. This isn't a guarantee — it's a token obligation that creates no meaningful alignment.

3. Measurement games compound the problem. PBMs define GDR using their own formulary claims system, which allows them to exclude specialty claims, adjust for mail order fills, and average across different member populations in ways that inflate the measured GDR above what the plan actually experiences. Without independent data verification rights and a contractually defined measurement methodology, every guarantee metric can be manipulated.

$ DOLLAR IMPACT — HOW THIS COSTS YOUR PLAN

For a 500-member plan on a traditional PBM model, a GDR guarantee miss of 3 percentage points (e.g., 82% actual vs. 85% guaranteed) represents approximately $27,000–$54,000 in avoidable brand drug overpayment. Claims processing accuracy misses add $5,000–$15,000/year in overpayment errors. A performance reconciliation structure with 10–15% of total PBM compensation at risk — vs. the typical 2–5% — creates $12,000–

$25,000/year in additional recoverable value for the plan. Annual retroactive reconciliation vs. quarterly measurement with cure periods represents an average of $8,000–$20,000/year in deferred recovery.

RED-FLAG LANGUAGE TO LOOK FOR IN YOUR CONTRACT

```
"Total performance guarantee at-risk amount shall not exceed 2% of annual administrative fees"
```

```
"Performance guarantee calculations are based on PBM's internal claims data and measurement methodology"
```

```
"PBM shall have a 90-day cure period to remediate any performance guarantee breach before financial penalties apply"
```

```
"Performance guarantees are the Plan's sole and exclusive remedy for PBM service failures"
```

REQUIRED FIX — ADD THIS LANGUAGE TO THE CONTRACT

Add: "Performance guarantees shall include a minimum generic dispensing rate (GDR) of 87%, formulary compliance rate of 92%, claims processing accuracy of 99.5%, and member satisfaction score of 85 or above, each measured quarterly based on independently verifiable data. No less than 12% of total annual PBM compensation shall be at risk across all performance guarantees. No cure period shall exceed 30 days. PBM shall provide Plan with quarterly performance reconciliation with retroactive financial adjustments for any guarantee miss, without Plan request."

⊗ Restricted data portability/export rights

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No commitment for full raw claim exports in standard layouts.

⚠ HOW PBMS EXPLOIT THIS GAP

1. Performance guarantee structures in PBM contracts are masterworks of apparent accountability with real-world unenforceability. The typical contract offers guarantees on generic dispensing rate (GDR), formulary compliance, claim processing accuracy, and member satisfaction — all of which sound meaningful and measurable. The exploitation is in the structure: guarantees are self-reported by the PBM using its own data systems, measurement methodology is defined by the PBM, cure periods allow the PBM to 'fix' performance after a breach is identified, and the total at-risk dollar amount is a fraction of actual PBM compensation.

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MET (1)

- Delayed or incomplete data access

  > *"PBM will provide Sponsor with a copy of the MAC List upon request."*

GAP SUMMARY

On-request, non-ownership posture preserves PBM's information advantage and inhibits oversight.

RECOMMENDED CONTRACT LANGUAGE

```
"All data generated under this Agreement are Sponsor-owned; PBM
provides monthly full-fidelity claim-level data and, upon
termination, a 36-month historical export in NCPDP and custom
analytic formats at no cost."
```

NEGOTIATION TALKING POINT

"Insert a data rights addendum; request sample exports and a data delivery SLA with penalties for delays."

SECTION 15

Negotiation Playbook

The following is a consolidated negotiation roadmap, ordered by provision severity. Use this as your primary action document in PBM renegotiation meetings. Each item includes a talking point and the contractual gap to close.

#1 Provision 7: Audit Rights & Recovery

RED FLAG

→ *"Require full data extract (claims, pricing, rebates) prior to renewal; propose independent auditor and pre-agree on sampling and variance thresholds."*

Gap: Absence of strong audit rights preserves PBM's information advantage and limits recovery of overpayments and withheld manufacturer value.

#2 Provision 12: Fiduciary & Legal Protections

RED FLAG

→ *"Require a fiduciary rider and conflict register with revenue categories; tie breaches to fee-at-risk and termination-for-cause."*

Gap: Absence of fiduciary duty and conflict disclosures permits the PBM to prioritize self-interest (owned channels, rebate retention) over Sponsor net cost.

#3 Provision 3: Rebates & Manufacturer Revenue

RED FLAG

→ *"Request manufacturer-level contracts for top 50 NDCs under NDA, a revenue taxonomy, and prior 12-month class-level ledger showing all monies by type vs. claim IDs; reconcile excluded 'ineligible' claims and quantify withheld value."*

Gap: Eligibility carve-outs and lack of 100% all-manufacturer-value pass-through enable PBM to retain significant off-invoice revenue, misaligning formulary incentives.

#4 Provision 9: Performance Guarantees

RED FLAG

→ *"Propose a value scorecard with quarterly settlement and transparent methodology; require claim-level backing data."*

Gap: No outcomes-based guarantees tied to net cost, biosimilar adoption, or service SLAs.

#5 Provision 13: Data Ownership & Access Rights

RED FLAG

→ *"Insert a data rights addendum; request sample exports and a data delivery SLA with penalties for delays."*

Gap: On-request, non-ownership posture preserves PBM's information advantage and inhibits oversight.

#6 Provision 2: Spread Pricing

RED FLAG

→ *"Demand a claim-level file (NCPDP fields) with pharmacy paid ingredient, DF, taxes, member cost share, and plan paid for every claim; require reconciliation of plan-billed vs. pharmacy-paid deltas with refund plus interest."*

Gap: No ban on spread and limited disclosure create a structural pathway for rent extraction between plan invoice and pharmacy payment.

#7 Provision 8: Transparency & Disclosure

RED FLAG

→ *"Request a data spec and sample feed; include a data-rights rider guaranteeing unrestricted use for audit and optimization."*

Gap: On-request and summary-level disclosures maintain opacity around the key money flows (MAC, ingredient cost, rebates).

#8 Provision 10: Termination & Exit Barriers

RED FLAG

→ *"Insist on penalty-free termination-for-convenience and pre-baked data transition package; quantify switching savings to counter any proposed fees."*

Gap: Potential lock-in through exit fees and data friction diminishes competitive discipline.

#9 Provision 6: Specialty Drug Management

CONCERN

→ *"Provide top-50 specialty NDCs with net cost after all manufacturer revenue; identify LDD vs. non-LDD and channel; deliver biosimilar adoption gap analysis with savings opportunity."*

Gap: Specialty class definitions and LDD constructs without pricing and rebate guardrails enable elevated net cost and PBM margin capture.

#10 Provision 4: Formulary Control

CONCERN

→ *"Demand 12-month change log of formulary actions with net cost modeling by NDC, including foregone rebate vs. acquisition cost; require biosimilar adoption plan with savings projections."*

Gap: Ambiguous control permits PBM to optimize rebate economics over net cost through tiering, exclusions, and utilization edits.

#11 Provision 5: Pharmacy Network Design

CONCERN

→ *"Request channel-by-channel rate cards and 12-month claims with pharmacy NPI, ingredient, DF, and PBM-owned flag; require side-by-side net cost vs. open network comparators."*

Gap: Ownership of mail/specialty and unilateral network pricing enable steering to higher-margin channels and spread via differential reimbursement.

#12 Provision 1: Pricing & Reimbursement

CONCERN

→ *"Provide last 12 months of MAC add/change/delete logs with effective dates, claim-level impact, and network appeals; specialty claims by NDC with paid rate vs. AWP at adjudication; channel-level dispensing fee schedules and effective dates."*

Gap: Unilateral benchmark and MAC controls enable PBM to set reimbursement economics and extract spread via opaque updates, channel-specific fees, and lack of specialty carve-out caps.

#13 Provision 11: Claim Adjudication Logic

CONCERN

→ *"Request a 12-month reprocessing ledger; implement a 7-day price freeze window and variance thresholds requiring Sponsor sign-off."*

Gap: Dynamic MAC updates and absent reprocessing disclosures allow PBM to alter paid amounts post-adjudication without sponsor visibility.

APPENDIX A · SECTION 16

Contract Evidence Register

Every issue evaluated during the AI contract review is listed below with its verbatim evidence — the exact language found in your contract (or a notation when no matching language was located). This register constitutes the primary audit trail for all scores in this report.

61	26	35	43%
TOTAL ISSUES REVIEWED	PROTECTIONS CONFIRMED	PROTECTIONS MISSING	EVIDENCE MATCH RATE

1 Pricing & Reimbursement

3 of 6 requirements confirmed · Score: 4.5/10

✓ 3 FOUND | ✕ 3 MISSING | Concern

01 ✓ FOUND

AWP/WAC/NADAC benchmark opacity

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

""Average Wholesale Price" or "AWP" means... published by MediSpan... PBM shall update AWP data no less than weekly."

AI ANALYSIS

No hierarchy or parity safeguards across AWP, WAC, NADAC; no anti-benchmark drift or substitution tests; no explicit repackager loophole closure beyond one condition.

02 ✕ MISSING

Spread between reimbursement benchmarks

No matching language identified in contract text.

AI ANALYSIS

No explicit parity between pharmacy reimbursement and plan billing; no guarantee of single-source pricing benchmark alignment across channels.

03 ✓ FOUND

MAC list manipulation flexibility

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

""Maximum Allowable Cost" or "MAC" means... included on the PBM's MAC List, which may be amended from time to time by PBM."

AI ANALYSIS

Unilateral MAC amendments without challenge/appeal SLA, disclosure cadence, or floor/ceiling constraints enable PBM to shift costs and spreads dynamically.

04 ✕ MISSING

Specialty drug pricing carve-outs

No matching language identified in contract text.

AI ANALYSIS

No explicit specialty discount guarantees, LDD rate caps, or buy-and-bill parity; PBM-owned specialty channels defined but not price-constrained.

05 ✓ FOUND

Dispensing fee variability asymmetry

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"“Dispensing Fee” means the service fee... added to the discounted AWP or MAC. No Dispensing Fee is added to the U&C."

AI ANALYSIS

No fixed, schedule-defined fees by channel; PBM can vary fees across networks/channels without sponsor parity commitments.

06 ✕ MISSING

Repricing or retroactive adjustments

No matching language identified in contract text.

AI ANALYSIS

No protections against retroactive price file changes or backdated MAC updates.

2 Spread Pricing

2 of 4 requirements confirmed · Score: 3.0/10

✓ 2 FOUND | ✕ 2 MISSING | Red Flag

01 ✕ MISSING

Explicit spread pricing clauses

No matching language identified in contract text.

AI ANALYSIS

No explicit prohibition that plan charges equal pharmacy reimbursements plus disclosed admin fee.

02 ✓ FOUND

Implicit spread via reimbursement gaps

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"PBM's MAC Lists and payment/cost schedules are frequently updated. PBM will provide Sponsor with a copy of the MAC List upon request."

AI ANALYSIS

MAC control + no billing parity enables implicit spread between plan invoice and pharmacy pay.

03 ✕ MISSING

Hidden spread via pharmacy clawbacks

No matching language identified in contract text.

AI ANALYSIS

No prohibition of DIR fees/GER reconciliations reducing pharmacy pay after adjudication.

04 ✓ FOUND

Spread non-disclosure to plan sponsor

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"PBM will provide Sponsor with a copy of the MAC List upon request."

AI ANALYSIS

Access only upon request; no ongoing, claim-level disclosure of pharmacy pay vs. plan bill.

3 Rebates & Manufacturer Revenue

4 of 6 requirements confirmed · Score: 2.5/10

✓ 4 FOUND | ✕ 2 MISSING | Red Flag

01 ✕ MISSING

PBM rebate retention rights

No matching language identified in contract text.

AI ANALYSIS

No explicit 100% pass-through of all manufacturer-derived revenue (formulary, admin, data, price-protection, inflation, guarantees).

02 ✕ MISSING

Delayed rebate remittance timing

No matching language identified in contract text.

AI ANALYSIS

No remittance deadlines or interest on late payments.

03 ✓ FOUND

Partial rebate pass-through structures

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Ineligible Claims... and Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."

AI ANALYSIS

Eligibility tied to PBM-manufacturer terms unknown to sponsor allows exclusion of value for covered utilization.

04 ✓ FOUND

Manufacturer contracting exclusivity control

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Formulary may be developed and approved by the PBM's P&T Committee..."

AI ANALYSIS

PBM can prefer manufacturers optimizing PBM revenue vs. plan net cost; no right for sponsor to audit contracts or opt-out.

05 ✓ FOUND

Rebate eligibility ambiguity

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Ineligible Claims... Claims for which a Plan or any of its Affiliates has obtained a direct or indirect price concession; ... 100% Member Paid Program Claims..."

AI ANALYSIS

PBM can exclude claims from rebate pass-through when other concessions exist or discount mechanisms are used, even if plan funds the claims.

06 ✓ FOUND

Off-invoice rebate capture risk

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Ineligible Claims... Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."

AI ANALYSIS

No requirement to pass through admin fees, data fees, price protection, inflation penalties, or guarantee true-ups.

4 Formulary Control

3 of 5 requirements confirmed · Score: 4.0/10

✓ 3 FOUND | ✕ 2 MISSING | Concern

01 ✓ FOUND

PBM unilateral formulary authority

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"For Medicaid and Commercial lines of business, the "Formulary" may be developed and approved by the PBM's P&T Committee and/or the Sponsor's P&T Committee."

AI ANALYSIS

Use of 'may' without default control, veto, or net-cost standard enables PBM to prioritize rebate yield.

02 ✕ MISSING

Step therapy enforcement control

No matching language identified in contract text.

AI ANALYSIS

No clarity on who sets/approves step and PA rules or appeals standards.

03 ✓ FOUND

Exclusion list opacity

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Formulary... quantity limits, prior authorization guidelines, and clinical guidelines..."

AI ANALYSIS

No requirement to disclose exclusion changes in advance or provide net-cost impact.

04 ✕ MISSING

Therapeutic substitution discretion

No matching language identified in contract text.

AI ANALYSIS

No constraints on PBM-driven therapeutic interchange programs.

05 ✓ FOUND

Tiering manipulation incentives

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Formulary may be developed and approved by the PBM's P&T Committee..."

AI ANALYSIS

No net-cost guardrails or biosimilar-first mandate.

5 Pharmacy Network Design

4 of 5 requirements confirmed · Score: 4.0/10

✓ 4 FOUND | ✕ 1 MISSING | Concern

01 ✕ MISSING

Preferred pharmacy steering

No matching language identified in contract text.

AI ANALYSIS

No disclosure on preferred tiers or cost parity requirements.

02 ✓ FOUND

Differential reimbursement across pharmacies

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"PBM's MAC Lists and payment/cost schedules are frequently updated."

AI ANALYSIS

No parity or MFN; PBM can set varying rates to manipulate channel economics.

03 ✓ FOUND

Mail-order coercion mechanisms

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Mail Order Pharmacy... contracted with and/or owned or operated by PBM."

AI ANALYSIS

Ownership without price-parity guarantees or opt-out rights risks coercive steering.

04 ✓ FOUND

Limited pharmacy network transparency

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"PBM will provide Sponsor with a copy of the MAC List upon request."

AI ANALYSIS

Access by request; no ongoing transparency to network rate schedules.

05 ✓ FOUND

Spread capture via network design

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"PBM's MAC Lists and payment/cost schedules are frequently updated."

AI ANALYSIS

No commitment to bill-at-pharmacy-pay; PBM can exploit differential rates.

6 Specialty Drug Management

3 of 5 requirements confirmed · Score: 3.5/10

✓ 3 FOUND | ✕ 2 MISSING | Concern

01 ✕ MISSING

Site-of-care steering restrictions

No matching language identified in contract text.

AI ANALYSIS

No rights for SOC optimization from hospital outpatient to home/ambulatory infusion.

02 ✕ MISSING

White/brown bagging mandates

No matching language identified in contract text.

AI ANALYSIS

No guardrails; PBM can mandate bagging via owned specialty without price parity or clinical exception path.

03 ✓ FOUND

Specialty carve-out opacity

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Limited Distribution Drug... dispensing is restricted by the pharmaceutical manufacturer to only 3 or fewer pharmacies."

AI ANALYSIS

No pricing caps or LDD differential controls.

04 ✓ FOUND

High-cost drug reimbursement manipulation

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Biosimilar Drugs are Brand Drugs, unless... required to be classified as Generic..."

AI ANALYSIS

Classification choices may diminish biosimilar discount targets and reporting; no biosimilar parity rule.

05 ✓ FOUND

Specialty rebate separation from plan sponsor

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Ineligible Claims... Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."

AI ANALYSIS

Rebate eligibility tied to PBM-manufacturer constructs can exclude specialty classes disproportionately.

7 Audit Rights & Recovery

0 of 5 requirements confirmed · Score: 2.0/10

✕ 5 MISSING | Red Flag

01 ✕ MISSING

Limited audit scope clauses

No matching language identified in contract text.

AI ANALYSIS

No affirmative audit scope defined; risk PBM restricts to summary reports.

02 ✕ MISSING

Short audit lookback windows

No matching language identified in contract text.

AI ANALYSIS

Lookback not stated; PBM can limit to 6-12 months.

03 ✕ MISSING

Data access restrictions during audit

No matching language identified in contract text.

AI ANALYSIS

No right to de-identified claim-level and contract/manufacturer documentation.

04 ✕ MISSING

Recovery limitations post-audit

No matching language identified in contract text.

AI ANALYSIS

No interest on recoveries or mandatory timing.

05 ✕ MISSING

PBM-controlled audit methodology

No matching language identified in contract text.

AI ANALYSIS

No sponsor right to select auditor or define sampling.

8 Transparency & Disclosure

3 of 5 requirements confirmed · Score: 3.0/10

✓ 3 FOUND | ✕ 2 MISSING | Red Flag

01 ✓ FOUND

"Proprietary information" shielding used to block pricing disclosure

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"PBM will provide Sponsor with a copy of the MAC List upon request."

AI ANALYSIS

On-request access signals PBM treats rate schedules and methodologies as proprietary, limiting proactive transparency.

02 ✕ MISSING

Lack of ingredient cost disclosure

No matching language identified in contract text.

AI ANALYSIS

No claim-level pharmacy paid ingredient and DF disclosure to sponsor.

03 ✓ FOUND

Black box rebate reporting

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."

AI ANALYSIS

Rebate flows governed by undisclosed manufacturer terms.

04 ✓ FOUND

Aggregate-only reporting structures

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"PBM will provide... MAC List upon request."

AI ANALYSIS

Signals summary-level access rather than automated claim-level feeds.

05 ✕ MISSING

Non-itemized claim-level visibility

No matching language identified in contract text.

AI ANALYSIS

No commitment to provide full NCPDP fields necessary to reconcile pricing and rebates.

9 Performance Guarantees

0 of 4 requirements confirmed · Score: 2.5/10

✕ 4 MISSING | Red Flag

01 ✕ MISSING

Weak or non-binding performance quality levels (PQLs)

No matching language identified in contract text.

AI ANALYSIS

No PQLs stated (call center, turnaround times, prior auth SLAs).

02 ✕ MISSING

Utilization threshold manipulation

No matching language identified in contract text.

AI ANALYSIS

No guarantee definitions for generic dispensing rate, formulary compliance, biosimilar uptake.

03 ✕ MISSING

Bonus-driven misalignment incentives

No matching language identified in contract text.

AI ANALYSIS

No alignment of PBM bonuses to sponsor net cost.

04 ✕ MISSING

Penalty avoidance loopholes

No matching language identified in contract text.

AI ANALYSIS

No liquidated damages or dollar-at-risk tied to measurable outcomes.

10 Termination & Exit Barriers

0 of 4 requirements confirmed · Score: 3.0/10

✕ 4 MISSING | Red Flag

01 ✕ MISSING

Early termination penalties

No matching language identified in contract text.

AI ANALYSIS

No termination rights/penalties listed; risk of punitive fees.

02 ✕ MISSING

Data export restrictions upon exit

No matching language identified in contract text.

AI ANALYSIS

No obligation to provide complete historical data in standard formats.

03 ✕ MISSING

Contract lock-in renewal structures

No matching language identified in contract text.

AI ANALYSIS

No auto-renewal notice windows specified.

04 ✕ MISSING

Financial penalties for switching PBMs

No matching language identified in contract text.

AI ANALYSIS

No penalty language visible; risk remains.

11 Claim Adjudication Logic

2 of 5 requirements confirmed · Score: 4.5/10

✓ 2 FOUND | ✕ 3 MISSING | Concern

01 ✕ MISSING — Retroactive claim adjustment authority

No matching language identified in contract text.

AI ANALYSIS

No limits on backdated adjustments.

02 ✕ MISSING — Reversal discretion without notice

No matching language identified in contract text.

AI ANALYSIS

No sponsor notice/approval for reversals.

03 ✓ FOUND — Pricing recalculation ambiguity

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"PBM's MAC Lists and payment/cost schedules are frequently updated."

AI ANALYSIS

Frequent updates without freeze windows create moving-target pricing.

04 ✕ MISSING — Claim reprocessing opacity

No matching language identified in contract text.

AI ANALYSIS

No obligation to disclose reprocessed claims and impact.

05 ✓ FOUND — Compound pricing transparency

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Compound Drugs shall be priced using the NCPDP D.0 standard which shall capture each ingredient used in the medication."

12 Fiduciary & Legal Protections

1 of 4 requirements confirmed · Score: 2.0/10

✓ 1 FOUND | ✕ 3 MISSING | Red Flag

01 ✕ MISSING

Explicit fiduciary duty disclaimers

No matching language identified in contract text.

AI ANALYSIS

No fiduciary duty acceptance to act in Sponsor's best interest.

02 ✕ MISSING

Indemnification asymmetry favoring PBM

No matching language identified in contract text.

AI ANALYSIS

No mutual indemnity terms provided.

03 ✕ MISSING

Liability limitation clauses

No matching language identified in contract text.

AI ANALYSIS

No caps or carve-outs reviewed; risk of low caps limiting recovery.

04 ✓ FOUND

Conflict-of-interest non-disclosure

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"Mail Order Pharmacy... owned or operated by PBM."

AI ANALYSIS

No disclosure and consent framework for owned channels and affiliate revenue.

13 Data Ownership & Access Rights

1 of 3 requirements confirmed · Score: 2.5/10

✓ 1 FOUND | ✕ 2 MISSING | Red Flag

01 ✕ MISSING **PBM ownership of claims data**

No matching language identified in contract text.

AI ANALYSIS

No explicit Sponsor ownership rights.

02 ✓ FOUND **Delayed or incomplete data access**

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"PBM will provide Sponsor with a copy of the MAC List upon request."

AI ANALYSIS

On-request framing implies PBM discretion on timing and completeness.

03 ✕ MISSING **Restricted data portability/export rights**

No matching language identified in contract text.

AI ANALYSIS

No commitment for full raw claim exports in standard layouts.

Evidence Register Notes: All quotes above are extracted verbatim from the submitted contract document by AI analysis. "Found" means the AI identified language that satisfies the protection criterion. "Missing" means no sufficient language was located. This register should be reviewed by qualified ERISA counsel to confirm AI extraction accuracy before relying on it for legal or fiduciary decisions.

APPENDIX B · SECTION 17

Score Calculation Sheet

A complete audit of every issue match and weighted score calculation. This sheet shows exactly how each provision score was derived from individual issues, and how the overall contract score was computed from the weighted provision scores.

SCORING FORMULA

Provision Score (0–10)

```
score = (issues_found / total_issues) × 10
```

Overall Contract Score (0–100)

```
overall = Σ(provision_score × weight) / Σ(weights) × 10
```

CAA 2026 priority weights assign higher importance to fiduciary alignment (Provision 1), spread pricing (Provision 2), and rebate pass-through (Provision 3) — reflecting the regulatory emphasis of the Consolidated Appropriations Act.

PROVISION SCORE SUMMARY

#	PROVISION	MET	TOTAL	SCORE	RATING	WEIGHT
1	Pricing & Reimbursement	3	6	4.5/10	Concern	10%
2	Spread Pricing	2	4	3.0/10	Red Flag	12%
3	Rebates & Manufacturer Revenue	4	6	2.5/10	Red Flag	12%
4	Formulary Control	3	5	4.0/10	Concern	7%
5	Pharmacy Network Design	4	5	4.0/10	Concern	8%
6	Specialty Drug Management	3	5	3.5/10	Concern	8%

7	Audit Rights & Recovery	0	5	2.0/10	Red Flag	8%
8	Transparency & Disclosure	3	5	3.0/10	Red Flag	8%
9	Performance Guarantees	0	4	2.5/10	Red Flag	7%
10	Termination & Exit Barriers	0	4	3.0/10	Red Flag	6%
11	Claim Adjudication Logic	2	5	4.5/10	Concern	5%
12	Fiduciary & Legal Protections	1	4	2.0/10	Red Flag	5%
13	Data Ownership & Access Rights	1	3	2.5/10	Red Flag	4%
	OVERALL	**26**	**61**	**37**/100		100%

FULL ISSUE MATCH LOG — ALL 61 ISSUES

Every issue evaluated in the AI analysis, showing the exact match result (✓ found / ✕ missing), the contribution to the provision score, and the score formula for each provision.

1 Pricing & Reimbursement — `(3/6) × 10 = 5`

01	✓	AWP/WAC/NADAC benchmark opacity	+1.67
02	✕	Spread between reimbursement benchmarks	+0.00
03	✓	MAC list manipulation flexibility	+1.67
04	✕	Specialty drug pricing carve-outs	+0.00
05	✓	Dispensing fee variability asymmetry	+1.67
06	✕	Repricing or retroactive adjustments	+0.00

2 Spread Pricing — `(2/4) × 10 = 5`

01	✗	Explicit spread pricing clauses	+0.00
02	✓	Implicit spread via reimbursement gaps	+2.50
03	✗	Hidden spread via pharmacy clawbacks	+0.00
04	✓	Spread non-disclosure to plan sponsor	+2.50

3 Rebates & Manufacturer Revenue

`(4/6) × 10 = 6.7`

01	✗	PBM rebate retention rights	+0.00
02	✗	Delayed rebate remittance timing	+0.00
03	✓	Partial rebate pass-through structures	+1.67
04	✓	Manufacturer contracting exclusivity control	+1.67
05	✓	Rebate eligibility ambiguity	+1.67
06	✓	Off-invoice rebate capture risk	+1.67

4 Formulary Control

`(3/5) × 10 = 6`

01	✓	PBM unilateral formulary authority	+2.00
02	✗	Step therapy enforcement control	+0.00
03	✓	Exclusion list opacity	+2.00
04	✗	Therapeutic substitution discretion	+0.00
05	✓	Tiering manipulation incentives	+2.00

5 Pharmacy Network Design

`(4/5) × 10 = 8`

01	✗	Preferred pharmacy steering	+0.00
02	✓	Differential reimbursement across pharmacies	+2.00
03	✓	Mail-order coercion mechanisms	+2.00
04	✓	Limited pharmacy network transparency	+2.00
05	✓	Spread capture via network design	+2.00

6 Specialty Drug Management

`(3/5) × 10 = 6`

01	✗	Site-of-care steering restrictions	+0.00
02	✗	White/brown bagging mandates	+0.00
03	✓	Specialty carve-out opacity	+2.00
04	✓	High-cost drug reimbursement manipulation	+2.00
05	✓	Specialty rebate separation from plan sponsor	+2.00

7 Audit Rights & Recovery

`(0/5) × 10 = 0`

01	✗	Limited audit scope clauses	+0.00
02	✗	Short audit lookback windows	+0.00
03	✗	Data access restrictions during audit	+0.00
04	✗	Recovery limitations post-audit	+0.00
05	✗	PBM-controlled audit methodology	+0.00

8 Transparency & Disclosure

`(3/5) × 10 = 6`

01	✓	"Proprietary information" shielding used to block pricing disclosure	+2.00
02	✗	Lack of ingredient cost disclosure	+0.00
03	✓	Black box rebate reporting	+2.00
04	✓	Aggregate-only reporting structures	+2.00
05	✗	Non-itemized claim-level visibility	+0.00

9 Performance Guarantees

`(0/4) × 10 = 0`

01	✗	Weak or non-binding performance quality levels (PQLs)	+0.00
02	✗	Utilization threshold manipulation	+0.00
03	✗	Bonus-driven misalignment incentives	+0.00
04	✗	Penalty avoidance loopholes	+0.00

10 Termination & Exit Barriers

`(0/4) × 10 = 0`

01	✗	Early termination penalties	+0.00

02	✗	Data export restrictions upon exit	+0.00
03	✗	Contract lock-in renewal structures	+0.00
04	✗	Financial penalties for switching PBMs	+0.00

11 Claim Adjudication Logic

`(2/5) × 10 = 4`

01	✗	Retroactive claim adjustment authority	+0.00
02	✗	Reversal discretion without notice	+0.00
03	✓	Pricing recalculation ambiguity	+2.00
04	✗	Claim reprocessing opacity	+0.00
05	✓	Compound pricing transparency	+2.00

12 Fiduciary & Legal Protections

`(1/4) × 10 = 2.5`

01	✗	Explicit fiduciary duty disclaimers	+0.00
02	✗	Indemnification asymmetry favoring PBM	+0.00
03	✗	Liability limitation clauses	+0.00
04	✓	Conflict-of-interest non-disclosure	+2.50

13 Data Ownership & Access Rights

`(1/3) × 10 = 3.3`

01	✗	PBM ownership of claims data	+0.00
02	✓	Delayed or incomplete data access	+3.33
03	✗	Restricted data portability/export rights	+0.00

OVERALL SCORE DERIVATION

$$(4.5 \times 10) + (3.0 \times 12) + (2.5 \times 12) + (4.0 \times 7) + (4.0 \times 8) + (3.5 \times 8) + (2.0 \times 8) + (3.0 \times 8) + (2.5 \times 7) + (3.0 \times 6) + (4.5 \times 5) + (2.0 \times 5) + (2.5 \times 4)$$

$$100 \text{ (total weight)} \times 10 = \mathbf{32}$$

37

OUT OF 100

SECTION 18

Methodology & Disclaimer

Scoring Framework

Each of the 13 provisions is evaluated against 4–6 specific issues (65 total). Each issue is scored as found (1) or not found (0). The provision score (0–10) is the weighted sum of issues met. The overall score (0–100) is the weighted average of all provision scores, adjusted for CAA 2026 priority weighting. 26 of 61 issues were found in this contract.

CAA 2026 Alignment

This framework is aligned with the Consolidated Appropriations Act of 2021, 2022, and 2026, which established PBM transparency requirements, fiduciary obligations, and pass-through pricing standards for self-funded group health plans. Provisions are weighted by their relevance to the CAA's core requirements.

AI Analysis

Contract text was analyzed using an AI language model trained on PBM contract standards, ERISA fiduciary requirements, and CAA 2026 compliance frameworks. The AI extracts relevant contract language, identifies gaps against each issue criterion, and scores each provision. Results are subject to the limitations of AI document analysis.

IMPORTANT DISCLAIMER

This report is for informational purposes only and does not constitute legal advice. Plan fiduciaries should consult qualified ERISA counsel before making contractual

decisions based on this analysis. Kincaid Health makes no representation as to the legal enforceability of any model contract language provided herein. This analysis is based solely on the contract text submitted — oral representations, side agreements, and business practices are not evaluated. Scores reflect the analysis of AI systems and should be verified by qualified legal and actuarial professionals.