PBM CONTRACT CLARITY 360™ · FIDUCIARY-GRADE PBM INTELLIGENCE

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August 31, 2026
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PBM CONTRACT FIDUCIARY ANALYSIS REPORT

Prime Therapeutics Management LLC

2025.01 ASA SIGNED (Prime) (6).pdf

38

OUT OF 100

RED FLAG

CAA 2026 Fiduciary Alignment Score
65 Issues · 13 Provisions Evaluated

4	24	36	13
CRITICAL FLAGS	ISSUES NOT MET	PROTECTIONS FOUND	PROVISIONS ANALYZED

KIQ **KINCAID HEALTH**
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SECTION 1

Critical Issues Ranked by Priority

The following 24 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 on spread (plan pay vs. pharmacy pay delta) by channel.

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

Provision 2: Spread Pricing

GAP

No prohibition on post-adjudication pharmacy fees (GER/BER/ADF) or DIR-like reconciliations.

03 **Site-of-care steering restrictions** RED FLAG

Provision 6: Specialty Drug Management

GAP

No language enabling lower-cost sites (home/ambulatory) or prohibiting PBM steering to high-cost channels.

04 **White/brown bagging mandates** RED FLAG

Provision 6: Specialty Drug Management

GAP

No prohibition or standards on white/brown bagging.

05

Limited audit scope clauses RED FLAG

Provision 7: Audit Rights & Recovery

GAP

No right to audit manufacturer contracts, pharmacy remittances, MAC methodologies.

06

Short audit lookback windows RED FLAG

Provision 7: Audit Rights & Recovery

GAP

No minimum 36-month lookback guarantee.

07

Recovery limitations post-audit RED FLAG

Provision 7: Audit Rights & Recovery

GAP

No explicit recovery rights, interest, or offset provisions.

08

PBM-controlled audit methodology RED FLAG

Provision 7: Audit Rights & Recovery

GAP

No sponsor-selected auditor or methodology rights.

09

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

Provision 9: Performance Guarantees

GAP

No guarantees on call center, turnaround times, or accuracy tied to penalties.

10

Bonus-driven misalignment incentives RED FLAG

Provision 9: Performance Guarantees

GAP

No prohibition on PBM receiving manufacturer bonuses tied to preferred placement without pass-through.

11 **Penalty avoidance loopholes** RED FLAG

Provision 9: Performance Guarantees

GAP

No liquidated damages, cure periods, or self-reporting obligations.

12 **Early termination penalties** RED FLAG

Provision 10: Termination & Exit Barriers

GAP

No termination for convenience or capped penalties disclosed.

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

Provision 10: Termination & Exit Barriers

GAP

No clarity on auto-renewal or rate review.

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

Provision 10: Termination & Exit Barriers

GAP

No waiver of termination fees upon PBM breach.

15 **Reversal discretion without notice** RED FLAG

Provision 11: Claim Adjudication Logic

GAP

No notice or approval for reversals and re-bills.

16 **Claim reprocessing opacity** RED FLAG

Provision 11: Claim Adjudication Logic

GAP

No reporting of reprocess reasons/codes at claim level.

17 **Indemnification asymmetry favoring PBM** RED FLAG

Provision 12: Fiduciary & Legal Protections

GAP

No reciprocal indemnities are visible.

18 **Liability limitation clauses** RED FLAG

Provision 12: Fiduciary & Legal Protections

GAP

No liability caps/ carve-outs presented.

19 **Spread between reimbursement benchmarks** CONCERN

Provision 1: Pricing & Reimbursement

GAP

No commitment to single benchmark or lesser-of U&C/MAC/AWP-WAC/NADAC; no clarity on acquisition cost vs. billed basis.

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

Provision 1: Pricing & Reimbursement

GAP

No specialty acquisition cost peg, no buy-and-bill parity, no LDD method disclosure.

21 **Repricing or retroactive adjustments** CONCERN

Provision 1: Pricing & Reimbursement

GAP

No prohibition or notice requirements for retroactive price changes or true-ups.

22

Delayed rebate remittance timing CONCERN

Provision 3: Rebates & Manufacturer Revenue

GAP

No remittance timeline, interest on late payments, or quarterly true-up standards.

23

Step therapy enforcement control CONCERN

Provision 4: Formulary Control

GAP

No policy clarity on ST/PA design rights or clinical governance.

24

Therapeutic substitution discretion CONCERN

Provision 4: Formulary Control

GAP

No restrictions on interchange or DAW handling rules beyond definitions.

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 commitment to single benchmark or lesser-of U&C/MAC/AWP-WAC/NADAC; no clarity on acquisition cost vs. billed basis.

⚠ 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 specialty acquisition cost peg, no buy-and-bill parity, no LDD method disclosure.

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No prohibition or notice requirements for retroactive price changes or true-ups.

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MET (3)

AWP/WAC/NADAC benchmark opacity

> *""Average Wholesale Price" or "AWP" means... published by MediSpan... PBM shall not allow adjudication of NDCs of licensed re-packagers where the data source identifies the licensed re-packagers AWP is greater than the original pharmaceutical AWP. PBM shall update AWP data no less than weekly."*

MAC list manipulation flexibility

> *""Maximum Allowable Cost"... may be amended from time to time by PBM. A "MAC List"... established, developed, adopted, and/or managed by PBM... PBM will provide Sponsor with a copy of the MAC List upon request."*

Dispensing fee variability asymmetry

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

GAP SUMMARY

PBM retains unilateral benchmark control (AWP anchor, mutable MAC, undefined lesser-of), enabling off-market pricing and after-the-fact repricing.

RECOMMENDED CONTRACT LANGUAGE

```
"PBM shall adjudicate claims on a Lesser-Of basis: (a) U&C; (b)
NADAC + $X.XX; (c) WAC + Y%; (d) AWP – Z%; (e) MAC (fixed) + DF.
MAC Lists shall be fixed for 30 days, with 7-day advance notice of
```

changes, appeal rights, and public-source validation. Specialty pricing shall be WAC + ≤2% with $0 adders unless expressly approved. Retroactive pricing changes are prohibited."

NEGOTIATION TALKING POINT

"Provide the full MAC lists (all variants) with historical change logs and claim-level mapping for the last 12 months; disclose bench-marking hierarchy and lesser-of stack actually used in production; produce top-25 specialty drugs pricing basis and compare to NADAC/WAC on each claim."

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 on spread (plan pay vs. pharmacy pay delta) by channel.

⚠ 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 on post-adjudication pharmacy fees (GER/BER/ADF) or DIR-like reconciliations.

⚠ HOW PBMS EXPLOIT THIS GAP

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MET (2)

- Implicit spread via reimbursement gaps

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

- Spread non-disclosure to plan sponsor

GAP SUMMARY

No spread ban and no transparent pharmacy-pay data; structure allows PBM to monetize deltas and post-period reconciliations.

RECOMMENDED CONTRACT LANGUAGE

```
"PBM shall operate on a 100% pass-through basis. Plan cost for each claim equals pharmacy remittance (ingredient + fee + tax) without markup. PBM warrants no post-adjudication pharmacy fees (GER/BER/DIR/ADF). Claim-level pharmacy remittance detail shall be provided monthly."
```

NEGOTIATION TALKING POINT

"Deliver 12 months of claim-level pharmacy remittance files and any GER/BER/DIR settlements; reconcile to plan-paid amounts to quantify spread by channel."

SECTION 4 · PROVISION 3 OF 10

Rebates & Manufacturer Revenue

3.5
OUT OF 10

CONCERN 5 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 — 1 PROTECTION MISSING

Delayed rebate remittance timing

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No remittance timeline, interest on late payments, or quarterly true-up standards.

⚠ 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."

MET (5)

PBM rebate retention rights

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

Partial rebate pass-through structures

""Ineligible Claims"... discount card, coupon program... EUA... Claims for which a Plan... has obtained a direct or indirect price concession; ... and Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."

Manufacturer contracting exclusivity control

"For Medicare Part D, the "Formulary" is developed and approved by PBM's P&T Committee and adopted by Sponsor."

Rebate eligibility ambiguity

> *"“Ineligible Claims” means… 100% Member Paid Program Claims… Claims for products used in the detection, prevention, or treatment of COVID-19… Claims for which a Plan… has obtained a direct or indirect price concession… and Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."*

Off-invoice rebate capture risk

GAP SUMMARY

Rebate flows are defined by undisclosed PBM-manufacturer agreements and broad ineligibility definitions; timing and completeness are unspecified.

RECOMMENDED CONTRACT LANGUAGE

```
"PBM shall remit 100% of all Manufacturer Revenue (rebates, admin fees, data fees, inflation/price-protection, formulary payments) attributable to Sponsor claims within 60 days post-quarter, with 1% monthly interest thereafter. No category exclusions absent Sponsor’s written consent. Claim-level eligibility files and manufacturer contracts subject to audit."
```

NEGOTIATION TALKING POINT

"Produce last 12 months: gross-to-net by NDC (claims, list WAC, all manufacturer monies by type, earned vs paid), contract eligibility matrices, and timing calendars; reconcile to plan-level rebate receipts."

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 policy clarity on ST/PA design rights or clinical governance.

⚠ 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 restrictions on interchange or DAW handling rules beyond definitions.

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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.

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MET (3)

PBM unilateral formulary authority

"For Medicare Part D, the "Formulary" is developed and approved by PBM's P&T Committee and adopted by Sponsor."

Exclusion list opacity

""Formulary" means... list of pharmaceutical products and supplies, quantity limits, prior authorization guidelines..."

Tiering manipulation incentives

""Brand Drug"... When a drug is classified as a Brand Drug, it shall be considered a Brand Drug for the purposes of measuring and reconciling financial guarantees."

GAP SUMMARY

Default PBM P&T control with limited oversight; economic levers (rebates/guarantees) can bias tiering and UM.

RECOMMENDED CONTRACT LANGUAGE

"Sponsor retains final formulary authority with 30-day advance notice of changes including clinical and net-cost impact modeling (after rebates and fees). PBM must implement Sponsor Custom Formulary without rebate penalties."

NEGOTIATION TALKING POINT

"Request prior-year formulary change log with net-cost impact per change (pre/post-rebate), and quantify member OOP effects; demand right to veto changes that increase net cost."

SECTION 6 · PROVISION 5 OF 10

Pharmacy Network Design

3.5
OUT OF 10

CONCERN 5 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)

MET (5)

- Preferred pharmacy steering

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

- Differential reimbursement across pharmacies

> *""Delivery Channel" means Retail 30, Retail 90, Retail Specialty, Mail, and Mail Specialty, individually."*

- Mail-order coercion mechanisms

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

- Limited pharmacy network transparency
- Spread capture via network design

GAP SUMMARY

Vertical integration + opaque channel pricing facilitates steering and spread retention.

RECOMMENDED CONTRACT LANGUAGE

```
"Network shall be open and non-discriminatory. Channel parity:
Mail/Mail Specialty unit costs shall be ≤ lowest Retail 90 network
rate on a net-of-rebate basis. PBM shall disclose acquisition-cost
basis for owned pharmacies and operate pass-through at claim
level."
```

NEGOTIATION TALKING POINT

"Request channel-by-channel unit cost benchmarks (AWP-%, WAC+%, DF), owned vs. independent pharmacy comparisons, and top-100 NDC claim-level remittance detail by channel."

SECTION 7 · PROVISION 6 OF 10

Specialty Drug Management

3.0
OUT OF 10

RED FLAG 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 language enabling lower-cost sites (home/ambulatory) or prohibiting PBM steering to high-cost channels.

⚠ 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 prohibition or standards on white/brown bagging.

⚠ 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"... "LDD Pharmacy"... "Mail Specialty" (implied via Delivery Channel)."

High-cost drug reimbursement manipulation

Specialty rebate separation from plan sponsor

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

GAP SUMMARY

Undefined specialty pricing and rebate terms allow PBM to capture significant margin on highest-cost drugs.

RECOMMENDED CONTRACT LANGUAGE

```
"Specialty pharmacy pricing shall be WAC + ≤2% with a fixed $X
dispense fee; all specialty manufacturer revenue at 100% pass-
through. Mandatory biosimilar-first where clinically appropriate;
site-of-care optimization program with measurable net savings
guarantees."
```

NEGOTIATION TALKING POINT

"Request 12-month specialty claims with NDC, site-of-care, channel, WAC at dispense, rebates/fees earned by NDC, and biosimilar uptake vs. class benchmarks; propose WAC+ contract conversion."

SECTION 8 · PROVISION 7 OF 10

Audit Rights & Recovery

2.5
OUT OF 10

RED FLAG 1 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 — 4 PROTECTIONS MISSING

Limited audit scope clauses

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No right to audit manufacturer contracts, pharmacy remittances, MAC methodologies.

⚠ 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

No minimum 36-month lookback guarantee.

⚠ 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 explicit recovery rights, interest, or offset provisions.

⚠ HOW PBMS EXPLOIT THIS GAP

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PBM-controlled audit methodology

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No sponsor-selected auditor or methodology rights.

⚠ 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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MET (1)

Data access restrictions during audit

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

GAP SUMMARY

Audit rights are undefined and data access is PBM-gated, reducing ability to detect and recover leakage.

RECOMMENDED CONTRACT LANGUAGE

"Sponsor may audit all financial elements (claims, pharmacy remittances, MAC methods, manufacturer contracts) for 36 months lookback. PBM to provide de-identified manufacturer terms under NDA. Underpayments bear 1% monthly interest; Sponsor may offset against fees."

NEGOTIATION TALKING POINT

"Commit to deliver claim-level data (Rx number, NDC, pharmacy pay, plan pay, fees, MAC values) and manufacturer revenue mappings within 10 business days upon request; include right to engage independent auditor."

SECTION 9 · PROVISION 8 OF 10

Transparency & Disclosure

2.5
OUT OF 10

RED FLAG 5 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)

MET (5)

- "Proprietary information" shielding used to block pricing disclosure

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

- Lack of ingredient cost disclosure
- Black box rebate reporting

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

- Aggregate-only reporting structures
- Non-itemized claim-level visibility

GAP SUMMARY

Opaque disclosures across pricing and rebates prevent validation, benchmarking, and recovery.

RECOMMENDED CONTRACT LANGUAGE

```
"PBM will provide monthly claim-level files including: NDC,
AWP/WAC/NADAC at dispense date, pharmacy remittance (ingredient,
fee), plan paid, member paid, MAC value, and all manufacturer
revenue attribution by claim. No proprietary shielding against
Sponsor/auditor under NDA."
```

NEGOTIATION TALKING POINT

"Demand claim-level transparency and a data dictionary; tie administrative fees to timely delivery and accuracy SLAs."

SECTION 10 · PROVISION 9 OF 10

Performance Guarantees

2.0
OUT OF 10

RED FLAG 1 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 — 3 PROTECTIONS MISSING**

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

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No guarantees on call center, turnaround times, or accuracy tied to penalties.

⚠ 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."

⊗ Bonus-driven misalignment incentives

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No prohibition on PBM receiving manufacturer bonuses tied to preferred placement without pass-through.

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Penalty avoidance loopholes

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No liquidated damages, cure periods, or self-reporting obligations.

⚠ HOW PBMS EXPLOIT THIS GAP

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MET (1)

Utilization threshold manipulation

""Brand Drug"... considered a Brand Drug for the purposes of measuring and reconciling financial guarantees."

GAP SUMMARY

No defined, enforceable guarantees linked to net cost outcomes; metrics risk being gamed.

RECOMMENDED CONTRACT LANGUAGE

"Implement at-risk fee model with ≥20% admin fee at-risk for net-cost PMPM, generic efficiency, biosimilar adoption, and service SLAs. Penalties auto-credit quarterly; no cure beyond 30 days unless Sponsor approves."

NEGOTIATION TALKING POINT

"Tie PBM compensation to net PMPM after all manufacturer revenue; require transparent methodology and third-party validation."

SECTION 11 · PROVISION 10 OF 10

Termination & Exit Barriers

3.0
OUT OF 10

RED FLAG 1 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 — 3 PROTECTIONS MISSING

Early termination penalties

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No termination for convenience or capped penalties disclosed.

⚠ 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."

Contract lock-in renewal structures

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No clarity on auto-renewal or rate review.

⚠ 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 waiver of termination fees upon PBM breach.

⚠ 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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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."

MET (1)

Data export restrictions upon exit

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

GAP SUMMARY

Exit terms and data portability undefined, creating switching frictions and potential penalties.

RECOMMENDED CONTRACT LANGUAGE

"Sponsor may terminate for convenience with 90 days' notice. Upon notice, PBM shall deliver 36 months of full claim-level and rebate attribution data within 15 business days, at no cost. No termination fees if PBM misses guarantees or breaches."

NEGOTIATION TALKING POINT

"Pre-negotiate exit data package and timelines; cap or eliminate termination fees tied to performance."

SECTION 12 · PROVISION 11 OF 10

Claim Adjudication Logic

3.0
OUT OF 10

RED FLAG 2 of 4 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 (4 ISSUES)

⊗ **NOT MET — 2 PROTECTIONS MISSING**

Reversal discretion without notice

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No notice or approval for reversals and re-bills.

⚠ 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."

Claim reprocessing opacity

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No reporting of reprocess reasons/codes at claim level.

⚠ 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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MET (2)

Retroactive claim adjustment authority

> *""Claims Runout" means a process whereby Claims incurred prior to the effective date of the termination... may properly be submitted after the effective date of termination."*

Pricing recalculation ambiguity

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

GAP SUMMARY

Dynamic schedules with no recalculation rules enable opaque repricing and retroactive financial drift.

RECOMMENDED CONTRACT LANGUAGE

```
"Pricing shall be determined at time-of-fill and not recalculated
post-adjudication except for member OOP corrections approved by
Sponsor. Any reprocessing >$500 requires prior notice and monthly
variance reporting."
```

NEGOTIATION TALKING POINT

"Require monthly adjudication variance reports: initial vs final allowed, reason codes, and financial deltas."

SECTION 13 · PROVISION 12 OF 10

Fiduciary & Legal Protections

2.0
OUT OF 10

RED FLAG 2 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 — 2 PROTECTIONS MISSING**

Indemnification asymmetry favoring PBM

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No reciprocal indemnities are visible.

⚠ 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."

Liability limitation clauses

AI ANALYSIS — WHAT WAS FOUND IN THIS CONTRACT

No liability caps/ carve-outs presented.

⚠ 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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MET (2)

- Explicit fiduciary duty disclaimers
- Conflict-of-interest non-disclosure

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

GAP SUMMARY

No affirmative fiduciary posture or COI transparency; remedies likely constrained by undisclosed limitations.

RECOMMENDED CONTRACT LANGUAGE

"PBM acknowledges a fiduciary duty to act solely in Sponsor's interest in managing the Plan's pharmacy benefit. PBM shall disclose all affiliate relationships and revenue flows. Liability cap shall exclude breach of fiduciary duty, gross negligence, fraud, data breaches, and confidentiality violations."

NEGOTIATION TALKING POINT

"Require written fiduciary acknowledgment and COI register covering all affiliates, with annual attestation."

SECTION 14 · PROVISION 13 OF 10

Data Ownership & Access Rights

2.5
OUT OF 10

RED FLAG 3 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)

✓ MET (3)

- PBM ownership of claims data

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

- Delayed or incomplete data access

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

- Restricted data portability/export rights

GAP SUMMARY

Data rights are undefined and access is PBM-gated, constraining analytics and portability.

RECOMMENDED CONTRACT LANGUAGE

```
"All plan-related data are the property of Sponsor. PBM will
provide monthly full-detail claim and rebate files in machine-
readable format within 5 business days of month-end and deliver 36
months of historical data within 10 business days upon request or
termination, at no cost."
```

NEGOTIATION TALKING POINT

"Insert data ownership and SLA clauses; demand sample files and data dictionary before execution."

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 9: Performance Guarantees

RED FLAG

→ *"Tie PBM compensation to net PMPM after all manufacturer revenue; require transparent methodology and third-party validation."*

Gap: No defined, enforceable guarantees linked to net cost outcomes; metrics risk being gamed.

#2 Provision 12: Fiduciary & Legal Protections

RED FLAG

→ *"Require written fiduciary acknowledgment and COI register covering all affiliates, with annual attestation."*

Gap: No affirmative fiduciary posture or COI transparency; remedies likely constrained by undisclosed limitations.

#3 Provision 7: Audit Rights & Recovery

RED FLAG

→ *"Commit to deliver claim-level data (Rx number, NDC, pharmacy pay, plan pay, fees, MAC values) and manufacturer revenue mappings within 10 business days upon request; include right to engage independent auditor."*

Gap: Audit rights are undefined and data access is PBM-gated, reducing ability to detect and recover leakage.

#4 Provision 8: Transparency & Disclosure

RED FLAG

→ *"Demand claim-level transparency and a data dictionary; tie administrative fees to timely delivery and accuracy SLAs."*

Gap: Opaque disclosures across pricing and rebates prevent validation, benchmarking, and recovery.

#5 Provision 13: Data Ownership & Access Rights

RED FLAG

→ *"Insert data ownership and SLA clauses; demand sample files and data dictionary before execution."*

Gap: Data rights are undefined and access is PBM-gated, constraining analytics and portability.

#6 Provision 2: Spread Pricing

RED FLAG

→ *"Deliver 12 months of claim-level pharmacy remittance files and any GER/BER/DIR settlements; reconcile to plan-paid amounts to quantify spread by channel."*

Gap: No spread ban and no transparent pharmacy-pay data; structure allows PBM to monetize deltas and post-period reconciliations.

#7 Provision 6: Specialty Drug Management

RED FLAG

→ *"Request 12-month specialty claims with NDC, site-of-care, channel, WAC at dispense, rebates/fees earned by NDC, and biosimilar uptake vs. class benchmarks; propose WAC+ contract conversion."*

Gap: Undefined specialty pricing and rebate terms allow PBM to capture significant margin on highest-cost drugs.

#8 Provision 10: Termination & Exit Barriers

RED FLAG

→ *"Pre-negotiate exit data package and timelines; cap or eliminate termination fees tied to performance."*

Gap: Exit terms and data portability undefined, creating switching frictions and potential penalties.

#9 Provision 11: Claim Adjudication Logic

RED FLAG

→ *"Require monthly adjudication variance reports: initial vs final allowed, reason codes, and financial deltas."*

Gap: Dynamic schedules with no recalculation rules enable opaque repricing and retroactive financial drift.

#10 Provision 3: Rebates & Manufacturer Revenue

CONCERN

→ *"Produce last 12 months: gross-to-net by NDC (claims, list WAC, all manufacturer monies by type, earned vs paid), contract eligibility matrices, and timing calendars; reconcile to plan-level rebate receipts."*

Gap: Rebate flows are defined by undisclosed PBM-manufacturer agreements and broad ineligibility definitions; timing and completeness are unspecified.

#11 Provision 5: Pharmacy Network Design

CONCERN

→ *"Request channel-by-channel unit cost benchmarks (AWP-%, WAC+%, DF), owned vs. independent pharmacy comparisons, and top-100 NDC claim-level remittance detail by channel."*

Gap: Vertical integration + opaque channel pricing facilitates steering and spread retention.

#12 Provision 4: Formulary Control

CONCERN

→ *"Request prior-year formulary change log with net-cost impact per change (pre/post-rebate), and quantify member OOP effects; demand right to veto changes that increase net cost."*

Gap: Default PBM P&T control with limited oversight; economic levers (rebates/guarantees) can bias tiering and UM.

#13 Provision 1: Pricing & Reimbursement

CONCERN

→ *"Provide the full MAC lists (all variants) with historical change logs and claim-level mapping for the last 12 months; disclose bench-marking hierarchy and lesser-of stack actually used in production; produce top-25 specialty drugs pricing basis and compare to NADAC/WAC on each claim."*

Gap: PBM retains unilateral benchmark control (AWP anchor, mutable MAC, undefined lesser-of), enabling off-market pricing and after-the-fact repricing.

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.

60	36	24	60%
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 not allow adjudication of NDCs of licensed re-packagers where the data source identifies the licensed re-packagers AWP is greater than the original pharmaceutical AWP. PBM shall update AWP data no less than weekly."

AI ANALYSIS

No WAC/NADAC fallback hierarchy, no acquisition-cost peg, no definition of 'lesser-of' logic hierarchy at point of sale.

02 ✕ MISSING

Spread between reimbursement benchmarks

No matching language identified in contract text.

AI ANALYSIS

No commitment to single benchmark or lesser-of U&C/MAC/AWP-WAC/NADAC; no clarity on acquisition cost vs. billed basis.

03 ✓ FOUND

MAC list manipulation flexibility

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

""Maximum Allowable Cost"... may be amended from time to time by PBM. A "MAC List"... established, developed, adopted, and/or managed by PBM... PBM will provide Sponsor with a copy of the MAC List upon request."

AI ANALYSIS

No change-controls, notice, appeals, or independent validation; PBM controls price and frequency.

04 ✕ MISSING

Specialty drug pricing carve-outs

No matching language identified in contract text.

AI ANALYSIS

No specialty acquisition cost peg, no buy-and-bill parity, no LDD method disclosure.

05 ✓ FOUND

Dispensing fee variability asymmetry

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

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

AI ANALYSIS

No fixed network-wide fees, no caps by channel, no specialty handling fee controls.

06 ✕ MISSING

Repricing or retroactive adjustments

No matching language identified in contract text.

AI ANALYSIS

No prohibition or notice requirements for retroactive price changes or true-ups.

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 on spread (plan pay vs. pharmacy pay delta) by channel.

02 ✓ FOUND

Implicit spread via reimbursement gaps

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

""Dispensing Fee"... added to the discounted AWP or MAC. No Dispensing Fee is added to the U&C."

AI ANALYSIS

Absence of claim-level disclosure of pharmacy remittance vs plan charge; undefined lesser-of hierarchy.

03 ✕ MISSING

Hidden spread via pharmacy clawbacks

No matching language identified in contract text.

AI ANALYSIS

No prohibition on post-adjudication pharmacy fees (GER/BER/ADF) or DIR-like reconciliations.

04 ✓ FOUND

Spread non-disclosure to plan sponsor

AI ANALYSIS

No clause requiring disclosure of pharmacy remittance data or itemized spread reporting.

3 Rebates & Manufacturer Revenue

5 of 6 requirements confirmed · Score: 3.5/10

✓ 5 FOUND | ✕ 1 MISSING | Concern

01 ✓ FOUND

PBM rebate retention rights

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

""“Ineligible Claims” means… Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."

AI ANALYSIS

No 100% pass-through commitment; PBM defines eligibility via manufacturer agreements not disclosed to Sponsor.

02 ✕ MISSING

Delayed rebate remittance timing

No matching language identified in contract text.

AI ANALYSIS

No remittance timeline, interest on late payments, or quarterly true-up standards.

03 ✓ FOUND

Partial rebate pass-through structures

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

""“Ineligible Claims”… discount card, coupon program… EUA… Claims for which a Plan… has obtained a direct or indirect price concession; … and Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."

AI ANALYSIS

Undefined share of total manufacturer revenue (admin fees, inflation, data fees, price-protection) to Sponsor.

04 ✓ FOUND

Manufacturer contracting exclusivity control

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"For Medicare Part D, the "Formulary" is developed and approved by PBM's P&T Committee and adopted by Sponsor."

AI ANALYSIS

Sponsor lacks explicit right to override rebate-driven exclusions/tiering without rebate forfeiture.

05 ✓ FOUND

Rebate eligibility ambiguity

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"“Ineligible Claims” means… 100% Member Paid Program Claims… Claims for products used in the detection, prevention, or treatment of COVID-19… Claims for which a Plan… has obtained a direct or indirect price concession… and Claims not otherwise eligible for Rebates under the applicable agreement with the manufacturer."

AI ANALYSIS

Sweeping exclusions enable PBM to deny rebates on material claim categories without disclosing manufacturer contract terms.

06 ✓ FOUND

Off-invoice rebate capture risk

AI ANALYSIS

No commitment to pass all manufacturer-derived monies (admin fees, price protection, data fees) at 100% to Sponsor.

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 Medicare Part D, the "Formulary" is developed and approved by PBM's P&T Committee and adopted by Sponsor."

AI ANALYSIS

No explicit Sponsor veto/advance notice/impact analysis; Custom Formulary option exists but requires Sponsor capacity.

02 ✕ MISSING

Step therapy enforcement control

No matching language identified in contract text.

AI ANALYSIS

No policy clarity on ST/PA design rights or clinical governance.

03 ✓ FOUND

Exclusion list opacity

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

""Formulary" means... list of pharmaceutical products and supplies, quantity limits, prior authorization guidelines..."

AI ANALYSIS

No requirement to disclose economic rationale for exclusions or provide impact modeling before adoption.

04 ✕ MISSING

Therapeutic substitution discretion

No matching language identified in contract text.

AI ANALYSIS

No restrictions on interchange or DAW handling rules beyond definitions.

05 ✓ FOUND

Tiering manipulation incentives

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

""Brand Drug"... When a drug is classified as a Brand Drug, it shall be considered a Brand Drug for the purposes of measuring and reconciling financial guarantees."

AI ANALYSIS

Brand/Generic classification locked to pricing guarantees can incentivize PBM to maintain brand placement to meet rebate targets.

5 Pharmacy Network Design

5 of 5 requirements confirmed · Score: 3.5/10

✓ 5 FOUND | Concern

01 ✓ FOUND

Preferred pharmacy steering

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

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

AI ANALYSIS

No guardrails preventing forced channeling to PBM-owned pharmacies.

02 ✓ FOUND

Differential reimbursement across pharmacies

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

""“Delivery Channel” means Retail 30, Retail 90, Retail Specialty, Mail, and Mail Specialty, individually."

AI ANALYSIS

No parity clauses or channel pricing ceilings.

03 ✓ FOUND

Mail-order coercion mechanisms

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

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

AI ANALYSIS

No explicit member choice protections or retail-90 parity.

04 ✓ FOUND

Limited pharmacy network transparency

AI ANALYSIS

No requirement to disclose network composition, access, or rate differentials.

05 ✓ FOUND

Spread capture via network design

AI ANALYSIS

No pass-through guarantee and PBM-owned pharmacies in network.

6 Specialty Drug Management

3 of 5 requirements confirmed · Score: 3.0/10

✓ 3 FOUND | ✕ 2 MISSING | Red Flag

01 ✕ MISSING

Site-of-care steering restrictions

No matching language identified in contract text.

AI ANALYSIS

No language enabling lower-cost sites (home/ambulatory) or prohibiting PBM steering to high-cost channels.

02 ✕ MISSING

White/brown bagging mandates

No matching language identified in contract text.

AI ANALYSIS

No prohibition or standards on white/brown bagging.

03 ✓ FOUND

Specialty carve-out opacity

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

""Limited Distribution Drug"... "LDD Pharmacy"... "Mail Specialty" (implied via Delivery Channel)."

AI ANALYSIS

No pricing constructs (WAC+/AWP-), LDD access rules, or rebate pass-through specificity for specialty.

04 ✓ FOUND

High-cost drug reimbursement manipulation

AI ANALYSIS

No cap on AWP inflation exposure or biosimilar adoption mandates.

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

No explicit specialty rebate pass-through; LDD/external channels may be excluded.

7 Audit Rights & Recovery

1 of 5 requirements confirmed · Score: 2.5/10

✓ 1 FOUND | ✕ 4 MISSING | Red Flag

01 ✕ MISSING

Limited audit scope clauses

No matching language identified in contract text.

AI ANALYSIS

No right to audit manufacturer contracts, pharmacy remittances, MAC methodologies.

02 ✕ MISSING

Short audit lookback windows

No matching language identified in contract text.

AI ANALYSIS

No minimum 36-month lookback guarantee.

03 ✓ FOUND

Data access restrictions during audit

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

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

AI ANALYSIS

Ad hoc 'upon request' implies PBM gatekeeping and potential delays; no commitment to raw claim-level data.

04 ✕ MISSING

Recovery limitations post-audit

No matching language identified in contract text.

AI ANALYSIS

No explicit recovery rights, interest, or offset provisions.

05 ✕ MISSING

PBM-controlled audit methodology

No matching language identified in contract text.

AI ANALYSIS

No sponsor-selected auditor or methodology rights.

8 Transparency & Disclosure

5 of 5 requirements confirmed · Score: 2.5/10

✓ 5 FOUND | 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

Selective disclosure suggests potential proprietary shielding elsewhere (rebates, contracts).

02 ✓ FOUND

Lack of ingredient cost disclosure

AI ANALYSIS

No pharmacy acquisition cost or NADAC benchmarking disclosure.

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

No obligation for line-level rebate attribution or disclosure of manufacturer agreements.

04 ✓ FOUND

Aggregate-only reporting structures

AI ANALYSIS

No itemized claim-level manufacturer revenue reporting.

05 ✓ FOUND

Non-itemized claim-level visibility

AI ANALYSIS

No commitment to provide claim-level fields (NDC, ingredient, fee, U&C, pharmacy pay).

9 Performance Guarantees

1 of 4 requirements confirmed · Score: 2.0/10

✓ 1 FOUND | ✕ 3 MISSING | Red Flag

01 ✕ MISSING

Weak or non-binding performance quality levels (PQLs)

No matching language identified in contract text.

AI ANALYSIS

No guarantees on call center, turnaround times, or accuracy tied to penalties.

02 ✓ FOUND

Utilization threshold manipulation

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

""Brand Drug"... considered a Brand Drug for the purposes of measuring and reconciling financial guarantees."

AI ANALYSIS

Guarantees may be defined in ways that reward brand utilization.

03 ✕ MISSING

Bonus-driven misalignment incentives

No matching language identified in contract text.

AI ANALYSIS

No prohibition on PBM receiving manufacturer bonuses tied to preferred placement without pass-through.

04 ✕ MISSING

Penalty avoidance loopholes

No matching language identified in contract text.

AI ANALYSIS

No liquidated damages, cure periods, or self-reporting obligations.

10 Termination & Exit Barriers

1 of 4 requirements confirmed · Score: 3.0/10

✓ 1 FOUND | ✕ 3 MISSING | Red Flag

01 ✕ MISSING

Early termination penalties

No matching language identified in contract text.

AI ANALYSIS

No termination for convenience or capped penalties disclosed.

02 ✓ FOUND

Data export restrictions upon exit

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

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

AI ANALYSIS

No explicit rights to full historical claim-level data and manufacturer revenue mapping in machine-readable format.

03 ✕ MISSING

Contract lock-in renewal structures

No matching language identified in contract text.

AI ANALYSIS

No clarity on auto-renewal or rate review.

04 ✕ MISSING

Financial penalties for switching PBMs

No matching language identified in contract text.

AI ANALYSIS

No waiver of termination fees upon PBM breach.

11 Claim Adjudication Logic

2 of 4 requirements confirmed · Score: 3.0/10

✓ 2 FOUND | ✕ 2 MISSING | Red Flag

01 ✓ FOUND

Retroactive claim adjustment authority

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

"“Claims Runout” means a process whereby Claims incurred prior to the effective date of the termination... may properly be submitted after the effective date of termination."

AI ANALYSIS

Runout defined but no limits on retroactive adjustments or sponsor approval.

02 ✕ MISSING

Reversal discretion without notice

No matching language identified in contract text.

AI ANALYSIS

No notice or approval for reversals and re-bills.

03 ✓ FOUND

Pricing recalculation ambiguity

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

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

AI ANALYSIS

No time-of-fill vs. time-of-pay rule hierarchy or freeze windows.

04 ✕ MISSING

Claim reprocessing opacity

No matching language identified in contract text.

AI ANALYSIS

No reporting of reprocess reasons/codes at claim level.

12 Fiduciary & Legal Protections

2 of 4 requirements confirmed · Score: 2.0/10

✓ 2 FOUND | ✕ 2 MISSING | Red Flag

01 ✓ FOUND **Explicit fiduciary duty disclaimers**

AI ANALYSIS

No affirmative fiduciary duty to act in Sponsor's best interest stated; likely disclaimed elsewhere.

02 ✕ MISSING **Indemnification asymmetry favoring PBM**

No matching language identified in contract text.

AI ANALYSIS

No reciprocal indemnities are visible.

03 ✕ MISSING **Liability limitation clauses**

No matching language identified in contract text.

AI ANALYSIS

No liability caps/ carve-outs presented.

04 ✓ FOUND **Conflict-of-interest non-disclosure**

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

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

AI ANALYSIS

No mandatory disclosure of affiliate relationships and revenue flows.

13 Data Ownership & Access Rights

3 of 3 requirements confirmed · Score: 2.5/10

✓ 3 FOUND | Red Flag

01 ✓ FOUND

PBM ownership of claims data

CONTRACT LANGUAGE CONFIRMING THIS PROTECTION

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

AI ANALYSIS

No explicit Sponsor ownership of all plan data and derivative data.

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 model without SLA for delivery or completeness.

03 ✓ FOUND

Restricted data portability/export rights

AI ANALYSIS

No explicit, no-cost export of full historical data upon termination.

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	5	6	3.5/10	Concern	12%
4	Formulary Control	3	5	4.0/10	Concern	7%
5	Pharmacy Network Design	5	5	3.5/10	Concern	8%
6	Specialty Drug Management	3	5	3.0/10	Red Flag	8%

7	Audit Rights & Recovery	1	5	2.5/10	Red Flag	8%
8	Transparency & Disclosure	5	5	2.5/10	Red Flag	8%
9	Performance Guarantees	1	4	2.0/10	Red Flag	7%
10	Termination & Exit Barriers	1	4	3.0/10	Red Flag	6%
11	Claim Adjudication Logic	2	4	3.0/10	Red Flag	5%
12	Fiduciary & Legal Protections	2	4	2.0/10	Red Flag	5%
13	Data Ownership & Access Rights	3	3	2.5/10	Red Flag	4%
	OVERALL	36	60	38/100		100%

FULL ISSUE MATCH LOG — ALL 60 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

`(5/6) × 10 = 8.3`

01	✓	PBM rebate retention rights	+1.67
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

`(5/5) × 10 = 10`

01	✓	Preferred pharmacy steering	+2.00
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

`(1/5) × 10 = 2`

01	✗	Limited audit scope clauses	+0.00
02	✗	Short audit lookback windows	+0.00
03	✓	Data access restrictions during audit	+2.00
04	✗	Recovery limitations post-audit	+0.00
05	✗	PBM-controlled audit methodology	+0.00

8 Transparency & Disclosure

`(5/5) × 10 = 10`

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

9 Performance Guarantees

`(1/4) × 10 = 2.5`

01	✗	Weak or non-binding performance quality levels (PQLs)	+0.00
02	✓	Utilization threshold manipulation	+2.50
03	✗	Bonus-driven misalignment incentives	+0.00
04	✗	Penalty avoidance loopholes	+0.00

10 Termination & Exit Barriers

`(1/4) × 10 = 2.5`

01	✗	Early termination penalties	+0.00

02	✓	Data export restrictions upon exit	+2.50
03	✗	Contract lock-in renewal structures	+0.00
04	✗	Financial penalties for switching PBMs	+0.00

11 Claim Adjudication Logic

`(2/4) × 10 = 5`

01	✓	Retroactive claim adjustment authority	+2.50
02	✗	Reversal discretion without notice	+0.00
03	✓	Pricing recalculation ambiguity	+2.50
04	✗	Claim reprocessing opacity	+0.00

12 Fiduciary & Legal Protections

`(2/4) × 10 = 5`

01	✓	Explicit fiduciary duty disclaimers	+2.50
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

`(3/3) × 10 = 10`

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

OVERALL SCORE DERIVATION

```
(4.5 × 10) + (3.0 × 12) + (3.5 × 12) + (4.0 × 7) + (3.5 × 8)
+ (3.0 × 8) + (2.5 × 8) + (2.5 × 8) + (2.0 × 7) + (3.0 × 6) +
(3.0 × 5) + (2.0 × 5) + (2.5 × 4)
```

`100 (total weight) × 10 = 31`

38

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. 36 of 60 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.