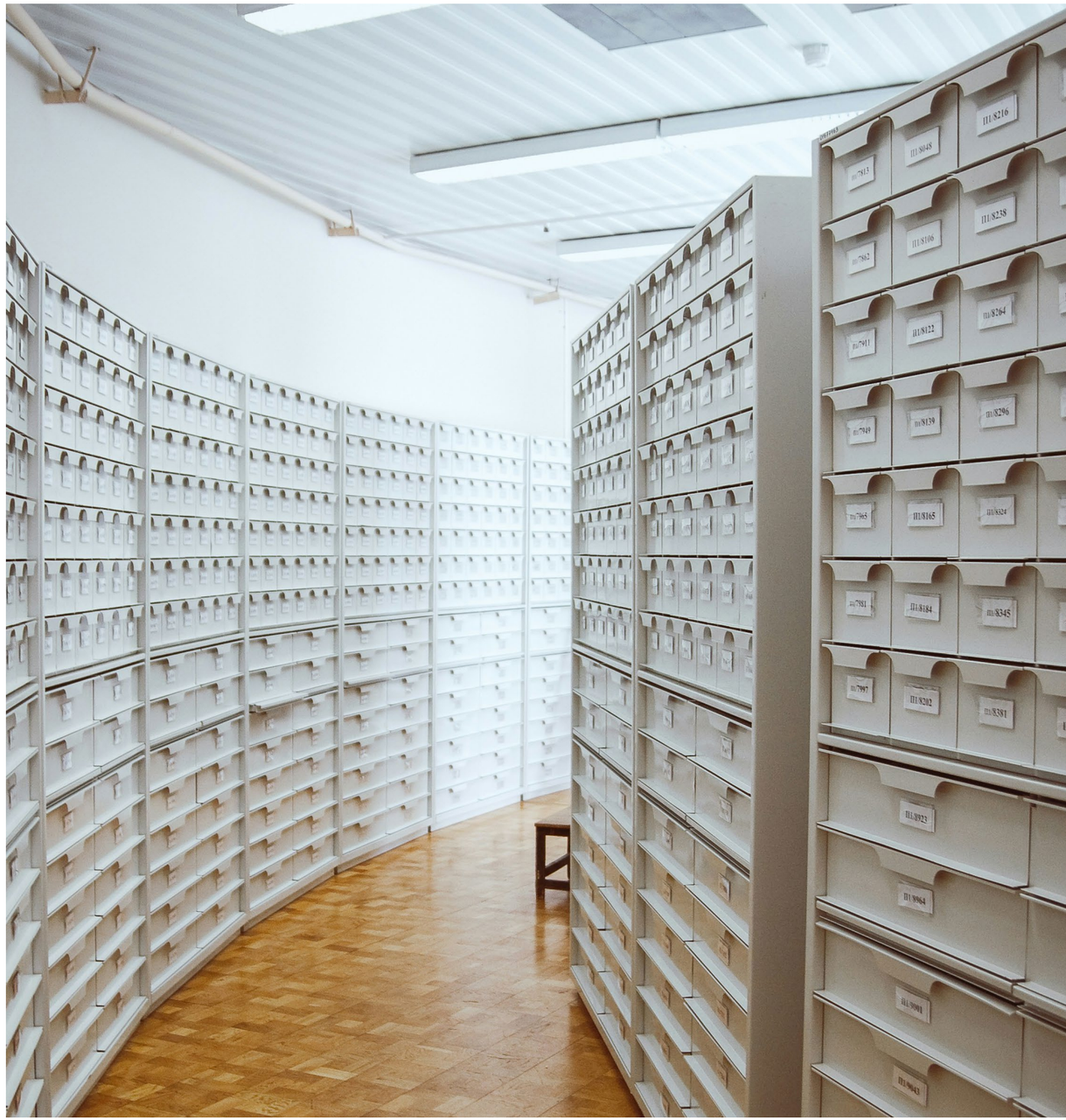
AArete®

Rethinking Your PBM Strategy: A Practical Guide for Payer Executives

Cut Through Complexity. Gain Control. Deliver Greater Value.

By Leslie Lotano-Saba, RPh, MS
Healthcare Consultant and Pharmacy Strategy Expert

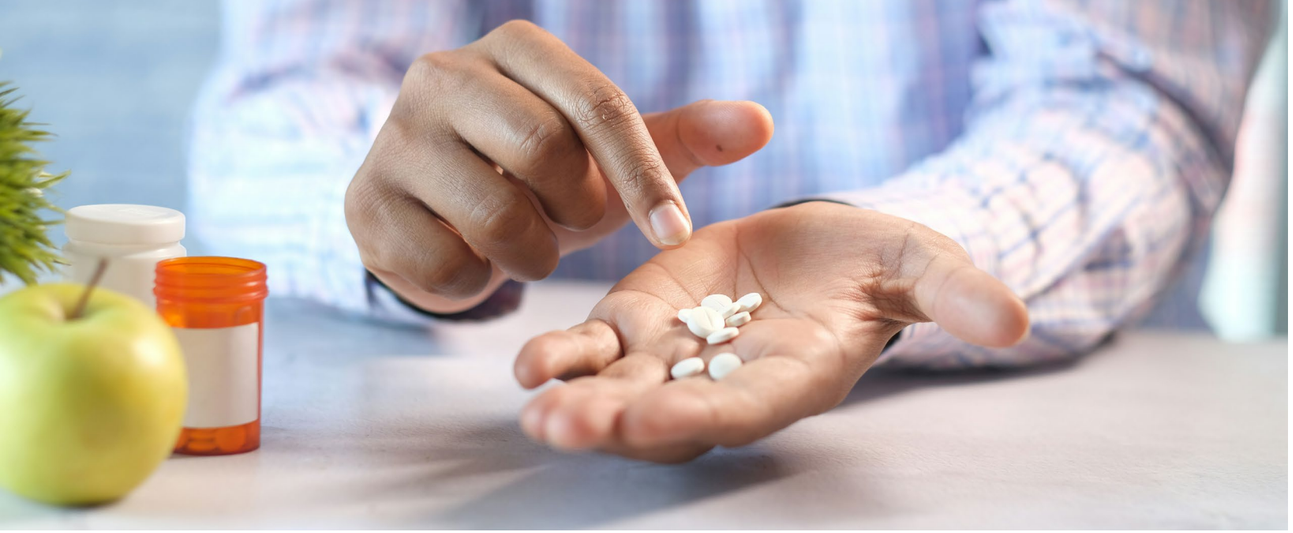
Table of Contents



Introduction

Health plans are under growing pressure to manage escalating pharmacy costs while improving transparency, aligning with value-based care, and delivering better outcomes for members. Yet many executives feel trapped in a cycle of opaque PBM contracts, rebate-driven incentives, and limited flexibility.

This guide is designed to help you take back control. Through a series of insights, you'll learn how to challenge outdated assumptions, explore smarter contracting models, and identify opportunities to optimize your PBM strategy—without disrupting service or sacrificing member satisfaction. Whether you're renegotiating, unbundling, or reevaluating your entire approach, these actionable strategies will empower you to make informed, sustainable decisions for your organization and the people you serve.



Dispelling PBM Myths: Tips for Creating Pharmacy Benefit Programs That Put Members First

Health plan executives often find themselves caught in a balancing act when it comes to delivering a valuable pharmacy benefit. On the one hand, members expect and deserve affordable, easy access to medications. On the other hand, prescription drug costs continue to rise at an unsustainable pace, forcing plans to pass some of those costs on to their members. Prescription drug spending increased by 11.4% to $449.7 billion in 2023, outpacing the 7.8% increase in 2022, according to the most recent National Health Expenditure data from the Centers for Medicare and Medicaid Services.

Finding a solution to this dilemma is difficult. Most payers rely heavily on Pharmacy Benefit Managers (PBMs) to handle several aspects of their pharmacy program. While today's market-leading PBMs have leveraged their scale to create models that efficiently manage volume, there are growing opportunities to enhance alignment with value-based care. Increasing transparency and realigning incentives toward cost-effective, clinically appropriate alternatives can help health plans gain greater influence over drug spend and trend—ultimately supporting more sustainable, member-centered outcomes.

This dynamic is particularly relevant for regional and nonprofit health plans, which often rely on a fully outsourced delegated PBM model and may have limited internal pharmacy leadership and analytic resources. As a result, it can be challenging to pinpoint drivers of rising costs.

Still, there are meaningful opportunities for health plans to optimize PBM relationships to reduce costs and improve member outcomes. By developing a deeper understanding of the pharmacy supply chain, where money flows, and the role of PBMs—plans can start adopting strategies to improve transparency, enhance value, and better support the health of their members.

UNPACKING THE PHARMACY SUPPLY CHAIN: A BRIEF PRIMER

The pharmacy supply chain starts with the manufacturer, which sets the initial price of medications, typically selling to wholesalers. Wholesalers then apply their own markup and sell to pharmacies.

PBMs occupy a crucial role between manufacturers, wholesalers, pharmacies and payers. They build and manage pharmacy networks for health plans, which includes contracting and credentialling, ensuring compliance with electronic records, processing claims and paying pharmacies. However, the relationship becomes more complex when the PBM owns pharmacies, is affiliated with payers, owns third-party administrators responsible for managing 340B programs, and owns group purchasing organizations responsible for negotiating and administering manufacturer rebates.

PBMs typically pay pharmacies based on the Average Wholesale Price (AWP). The AWP is considered the benchmark in the PBM industry and is a manufacturer-suggested price ("list price") rather than an actual average of wholesale transactions. However, it doesn't account for discounts pharmacies may receive through bulk purchasing or early payments. AWP is not regulated by the government and doesn't represent actual market prices. It's only a starting point for negotiations between PBMs, pharmacies, and payers.

Rebates add another layer of complexity. Manufacturers offer rebates to PBMs to incentivize the utilization of certain brand drugs, particularly specialty medications. While the majority of these rebates are passed down to health plans, a small portion stays with the PBM, and almost none of the rebates are passed on to the member.

With concerns about these practices growing, health plans might feel they have limited control over rising costs—but in fact, they have more leverage than they realize.

DEBUNKING COMMON PBM MYTHS

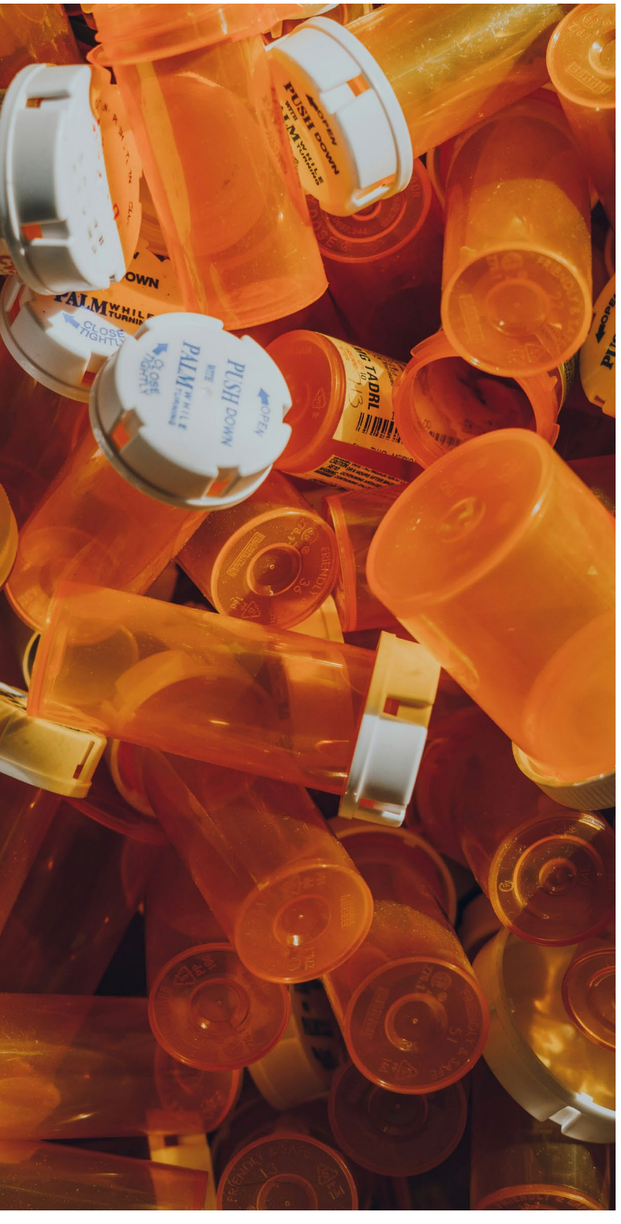
Before resetting their PBM relationships, health plan leaders must address three common myths that can cloud decision-making:

MYTH #1: LARGER PBMS OFFER HEALTH PLANS DEEPER DRUG DISCOUNTS.

While it's true that large PBMs leverage their size to negotiate deeper pharmacy network discounts and higher rebates, their business models are not always aligned with health plans' goals. Therefore, a larger PBM may not always be the best option for controlling costs.

MYTH #2: PBMS EFFECTIVELY CONTROL DRUG COSTS.

PBMs negotiate discounts via rebates, but several factors undermine their effectiveness. PBM owned group purchasing organizations (GPOs) are paid by manufacturers to administer rebate programs.



Rebates are based on the wholesale cost of the drugs. The higher the unit cost, the higher the rebate. Not all of these rebate payments are required to be passed on to the plan or the members. To maximize rebates, PBMs create formularies that promote utilization of high cost and high rebate drugs rather than those that are most cost-effective for the plan and its members. Moreover, rebates don't directly reduce members' out-of-pocket costs because they are calculated and paid after the pharmacy transaction. As a result, members end up on high-cost drugs, with no rebate offset that continue to rise in price to maintain rebate structures.

MYTH #3: HEALTH PLANS NEED A LARGE PBM TO GET MAXIMUM VALUE.

There's a common belief that only the "Big Three" PBMs can offer the best network and rebates. However, smaller, regional PBMs can deliver significant value, especially for plans that are regional or have members concentrated in a few states. These plans can leverage local care providers to offer a tailored network and cost-effective pricing without relying on the massive scale of large PBMs.

SIX STRATEGIES TO CONTROL COSTS AND ENHANCE MEMBER VALUE

By understanding how PBMs work, health plans can effectively manage expenses and enhance the value they provide to members. Here are some actionable steps:

1. SEEK TRANSPARENCY IN PBM CONTRACTS

Health plans should consider conducting a comprehensive Request for Proposal (RFP) process. Engaging with smaller and mid-tier PBMs that offer more transparency, and flexibility can provide health plans more control over formularies, benefit design and pricing models. While these PBMs may charge higher administrative fees upfront, plans can model the ROI and ultimately reduce net pharmacy costs for the plan and members.

2. ENSURE MARKET COMPETITIVENESS

Regularly evaluate the competitiveness of your PBM contract to ensure alignment with market dynamics and industry benchmarks. Staying current helps safeguard financial performance and maintain optimal pricing.

3. RENEGOTIATE PBM CONTRACTS

Health plans can remain with their current PBM and still achieve better outcomes by negotiating more transparent terms. Plans with PBM contracts that have been amended several times are likely to have significant opportunities to improve terms.

4. FOCUS ON RIGOROUS CONTRACT MANAGEMENT

Contract clarity is key to maximizing the benefits of your PBM relationship. Ensure that contract terms are well-defined, especially in areas like drug classification and rebate structures. This will help prevent ambiguity and improve pricing transparency.

5. MOVE AWAY FROM A REBATE-CENTRIC MODEL

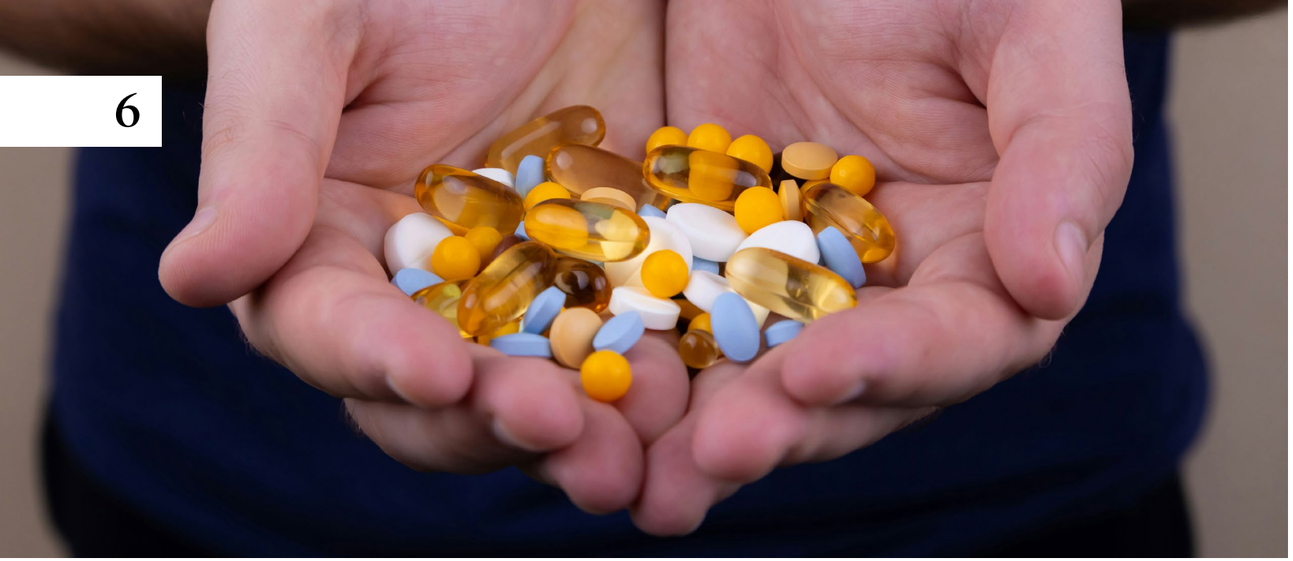
Rather than focusing on maximizing rebate revenue, health plans should shift toward achieving the lowest net costs. Most drugs within a therapeutic category offer similar clinical efficacy, so opting for cost-effective generics or biosimilars rather than those with high rebates can lead to substantial savings.

6. CONSIDER UNBUNDLING PBM SERVICES

Not all services offered by large PBMs are necessary for every health plan. For smaller or regional plans, it may be worth considering unbundling PBM functions and contracting directly with third-parties such as a claims processor to gain greater transparency and control.

THE VALUE OF AN UNBIASED PARTNER

Navigating the complexities of pharmacy benefit management requires expertise and impartial guidance. Health plans should seek partners who offer unbiased advice and deep real-world experience in the pharmacy benefit management space. By working with a trusted partner, health plan leaders can build transparent, cost-effective pharmacy benefit programs that provide real value to both their organization and their members.



Considering PBM Unbundling? Here's How to Take the First Step

Everything old, it seems, becomes new again, and so it is with health plans and their renewed interest in unbundling their Pharmacy Benefit Manager (PBM) relationships.

This trend first emerged in the early 2000s as payers began building their own pharmacy networks, contracting with manufacturers directly for rebates, and forging separate relationships with claims processors. In response, PBMs further incentivized, offering deeper discounts to payer partners to sustain or grow their prominence. Sure enough, in a few years, the pendulum swung back toward full-service PBM offerings and away from disintermediation.

Today, however, the PBM uncoupling movement is making a comeback, led by some of the largest health plans in the country. Given this resurgence, it's worth exploring which organizations may benefit most from a disintermediated model, key considerations for plans that choose to bring more services in-house, and where to begin.

WEIGH THE PROS AND CONS

While unbundling can be effective, it's not an elixir for all payer organizations. Plans that are ready for change—and willing to commit the resources to conduct a thorough assessment up front—will see the biggest benefits. Consider three crucial elements while evaluating whether disintermediation is the right move:

1. FINE-TUNE THE VISION.

Before issuing an RFP and selecting vendors to assume some or all of a PBM's responsibilities, payers should establish a vision and clear goals. In other words, they need to think about what they want to be when they grow up.

A tech-savvy organization, for example, might use unbundling as a springboard to create a streamlined clinical integration platform where members can view all their benefits information in one place instead of using multiple apps. Meanwhile, a regional plan may find that breaking away from a traditional PBM opens the door to building a localized pharmacy network better suited to their members' needs. These goals will be specific to each plan and serve as the North Star for success.

2. EVALUATE THE COSTS.

Payer organizations should thoroughly assess their current pharmacy benefit programs and analyze the full costs, including financial and human resources. When performing this exercise, some leaders may be shocked to learn how many staffers they currently devote to managing a full-service PBM relationship. By choosing disintermediation, plans can redeploy these resources to oversee multiple vendors and support both member experience and quality improvement initiatives. Creating a detailed financial projection model that precisely measures expenses and return on investment represents a crucial component in developing strategic plans and making sound business decisions.

3. GAIN LEADERSHIP ALIGNMENT.

Although unbundling aims to improve transparency, flexibility and control of a plan's pharmacy benefit, it's not a pharmacy director initiative alone—it's a company-wide effort. Much like switching medical claims systems, taking on key aspects of a third-party PBM's work will have a ripple effect throughout an organization. Accordingly, pharmacy leadership and other senior executives must be completely aligned before any disintermediation work begins, or the initiative is bound to fail.

RIP-AND-REPLACE NOT NEEDED

Yes, some larger organizations have gone from 0 to 60 mph in their transition, fully dismantling their full-service pharmacy benefit model and bringing the entire process in-house. For most others, however, this approach may cause too much disruption, too fast.

An alternative approach is transitioning to a hybrid model as a first step, where the health plan takes on certain components that align with their core competencies and business strategies. The hybrid model allows organizations to "get their feet wet" and gain more control over their pharmacy program before diving into the deep end of the unbundling pool.

For some, a hybrid model may include taking over formulary development and clinical policies. Others may choose to handle utilization management edits and prior authorization in house.

In fact, prior authorizations represent a prime opportunity for payers. PBMs and their affiliated pharmacy partners are not always aligned on utilization management priorities. By bringing prior authorizations in house, plans will gain more control over the process and effectiveness, thereby improving cost management.

GRADUALLY MOVE MORE SERVICES IN-HOUSE

As health plans grow more confident bringing services in house with a hybrid model, they can start seeking more ways to decrease costs and improve member satisfaction.

One area ripe for improvement is specialty drug management, which typically accounts for more than 50% of a health plan's drug spend for less than 5% of their membership. By contracting directly with specialty pharmacies, payers may improve member access and better control costs. Some plans could even take on the extra step of contracting with a rebate aggregator directly and then passing the savings on to their members. Taking these steps will require shrewd negotiation with the PBM, as most will want to maintain authority over these crucial areas.

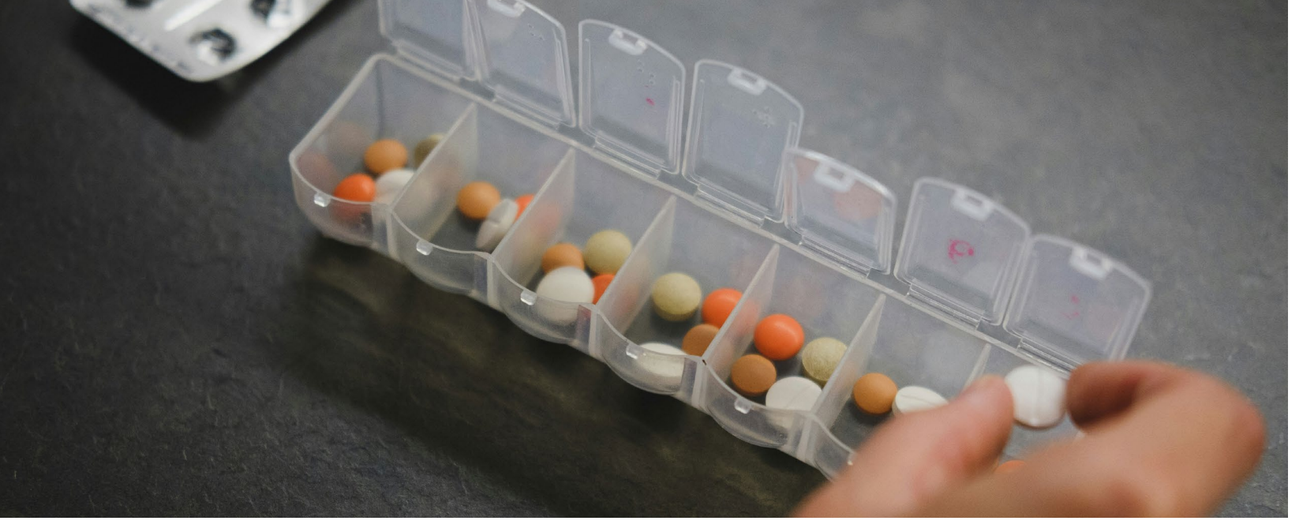
SEEK EXPERT GUIDANCE WITH PBM UNBUNDLING

As the old song goes, breaking up (with your PBM) is hard to do. Execution is always a risk. That's why it's essential to seek independent advisors who can provide a clear, actionable strategic plan backed by a well-defined transformation strategy.

A trusted partner should bring real-world experience within health plans or PBMs to impart direct knowledge and expertise to various stages of PBM transformation, from early assessment through implementation. The right advisor will help evaluate your current PBM operating model, identify what's working (and what's not), and support the development of a long-term strategy aligned with your organization's goals.

They should also take a holistic view—considering both pharmacy and medical benefits—to build a comprehensive drug optimization strategy that empowers members to access the most appropriate, cost-effective medications. A thoughtful partner will assess your organization's appetite for change, guide you through the process, and help position your plan for a successful, sustainable transformation.

> ***Choose a partner who prioritizes your goals, offers unbiased guidance, and has the expertise to help you deliver greater value to both your organization and your members.***



Inside the PBM Contract Renewal Conundrum: Breaking the Endless Loop

Contracts between health plans and their Pharmacy Benefit Managers (PBMs) can be opaque. Yet one fact is crystal clear: rising prescription drug costs are putting significant pressure on payer organizations of all types and sizes.

Escalating costs don't only hurt a health plan's bottom line. They also force payers to push a higher percentage of costs onto their members. High costs can disrupt access to the drugs they need. This puts payers in a no-win situation and members blame their insurers for rising out of pocket costs.

An added challenge is the recurring cycle of three-year PBM contracts and early renewals, which can limit options for payer executives if not carefully negotiated. So, how can plan leaders negotiate better deals with their current PBM providers or reinvent their pharmacy programs? The best approach is to understand the typical contract renewal process, evaluate the organization's total drug spend, gain a better understanding of the cost of running the pharmacy program, and deploy strategies that can lead to significant savings.

UNDERSTANDING THE TYPICAL PBM CONTRACT CYCLE

The standard three-year PBM agreement involves increasing annual price discounts to reflect anticipated market trends and cost inflation. In Year One, executives are often excited about the potential for significant savings through improved network discounts and improved rebates.

But between Years One and Two, leaders may realize that these rebates aren't offsetting their plan's drug spending as much as expected. At this stage, they might engage with a consultant and conduct a market check to assess the competitiveness of their drug pricing.

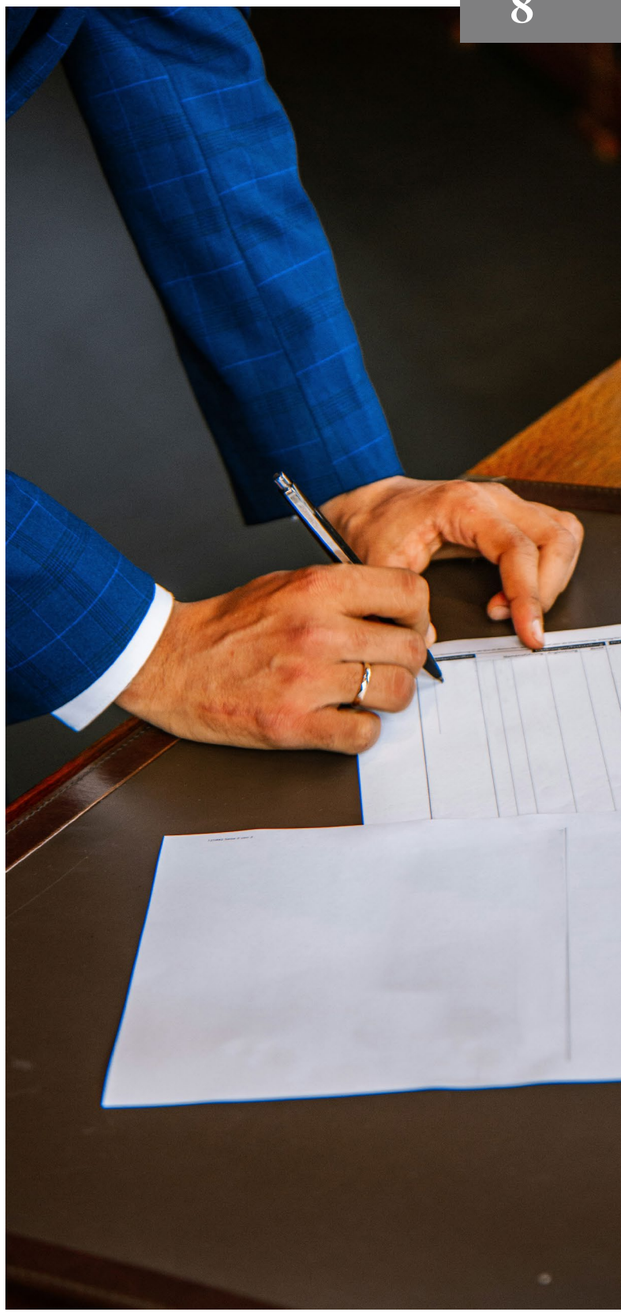
A market check is a powerful renegotiating tool, often prompting payers to bring their PBM partners back to the table. Fortunately, most three-year PBM agreements allow for a market check in Year Two. If market intelligence proves the PBM rates are not competitive, a negotiation may begin.

However, some PBMs counter by "backing up the money truck," offering hefty incentives, sometimes worth millions, that kick in only if the plan agrees to an early renewal. Usually, payers take the offer, locking themselves into new pricing terms for another three years through an amendment. Year One of the amendment generates savings, but as prices continue to increase, the Year Two market check is initiated, and the cycle continues.

WHY THREE-YEAR AGREEMENTS LEAVE FEW OPTIONS FOR PAYERS

Caught in the cycle of recurring three-year contracts, payers often struggle to gain leverage in their PBM relationships. Some payers may choose to exercise an early termination clause, but the substantial financial penalties and fear of converting to another PBM may outweigh the benefits of disrupting a PBM relationship mid-stream.

Another option is issuing an RFP, which can strengthen a plan's bargaining power. However, running a full-scale RFP requires significant time and resources, something most payer organizations simply don't have. Unless a plan is deeply dissatisfied with its PBM, the RFP tends to be a process of price checking for negotiating another 3-year term rather than a serious consideration for switching PBMs for overall improvement.



Health plan executives could also try asking their current PBMs partners for shorter contract terms. Some might agree, but others, especially the larger PBMs, will say no.

NEED MORE LEVERAGE? READ THE FINE PRINT

When an early exit, RFP, or shorter agreement isn't an option, payers can gain more negotiating power by taking a closer look at their existing contracts. Three red flags to watch for:

- **Contracts with multiple amendments.** PBMs may add amendments and addendums to contracts at renewal, inserting language that dilutes the stipulations in the original agreement. Look for trigger terms like "except" and "therefore," which could negate more positive arrangements defined earlier in the contract.

- **Exclusions.** Most PBM contracts exclude certain drugs or claim types) from rebate guarantees or guaranteed pricing. The volume of excluded claims is on the rise.

- **Excessive performance guarantees.** Adding more performance guarantees may seem like a way to exert more control over a contract. But these guarantees tend to lose their effectiveness at a certain point, because the PBMs cap how much money they are willing to risk. Even a health plan that spends $2 billion a year on drugs may find that their PBM is willing to put only $5 million at risk for missing performance guarantees, which is too small to make a real bottom-line difference.

RENEGOTIATE OR REVAMP?

If renegotiation doesn't sufficiently lower pharmacy costs, executives may consider overhauling their entire pharmacy benefit. Options for this could include exploring cost-plus or transparent PBM partners, or selecting a different PBM for specific segments, like Medicare members.

However, before committing to a full or partial revamp, plans should assess their capacity for such a major undertaking. Here are two considerations to guide this process:

- **Understand the full cost of managing the current pharmacy program.** While many organizations track drug spending as a percentage of total expenses, they often overlook the extra administrative costs related to medical, operational, legal, regulatory and compliance tasks. When these hidden expenses are revealed, plans are surprised by the true cost of managing their PBM relationship and the overall pharmacy program.

- **Elevate pharmacy leadership.** Pharmacy leaders are best positioned to understand the full impact of drug spending within their organizations. But if they sit five levels below the chief executive officer, their ability to drive organizational-wide change is limited—and they spend too much time educating multiple layers of management rather than shaping strategy. Elevating pharmacy leadership to the executive level helps unify pharmacy, medical, and operational leadership for stronger decision-making.

This approach creates the foundation for a comprehensive drug management strategy that addresses cost containment, improved utilization management, and better member outcomes.

ENGAGE UNBIASED EXPERTS FOR YOUR PBM STRATEGY

Weighing the short-term appeal of PBM renewal incentives against the long-term risk of rising costs is a complex challenge. That's why it's essential to seek guidance from unbiased experts who understand every facet of the pharmacy supply chain and can align drug management strategies with your organization's vision, mission, goals, and core competencies.

The right partner will objectively assess your current strategy, evaluate your capacity for change, and deliver tailored recommendations that support long-term sustainability and member impact. With the right insights, health plans can uncover more cost-control options than they may have realized.

Choose a partner who brings impartial expertise, aligns with your values, and is committed to helping you build a more strategic, cost-effective, and member-focused PBM approach.

AArete

AArete

Choose Clarity. Choose Confidence. Choose AArete.

Navigating pharmacy benefit decisions is complex—but you don't have to do it alone. AArete offers unbiased, data-driven guidance focused solely on your health plan's best interests. We don't promote any specific vendor or solution—we're here to serve you.

From evaluating your current model to designing a smarter, more sustainable strategy, we simplify the path forward. Let's take the complexity out of PBM transformation—together.

Humanizing Data for Purposeful Change® | AArete.com

Forbes 2025 AMERICA'S BEST MANAGEMENT CONSULTING FIRMS POWERED BY statista

2021, 2022, 2025

WORLD'S BEST MANAGEMENT CONSULTING FIRMS Forbes 2024 POWERED BY STATISTA

2022, 2023, 2024

MEMBERSHIPS: WBL Women Leading Health Care · ACAP Association for Community Affiliated Plans · TAHP The Texas Association of Health Plans

FEATURED IN: Modern Healthcare · Managed Healthcare Executive · AISHEALTH

120+

Health Plans Served

9 of the Top 10 Plans[1]

Serving plans across all U.S. markets, lines of business, and plan types:

- Large national payers
- Blues plans
- Provider-sponsored plans
- Regional plans

ABOUT AARETE

AArete is a global management and technology consulting firm specializing in driving profitability improvement, digital transformation, and strategy & change for clients. Our cross-industry solutions are powered by a digital-first mindset, market intelligence and data-driven approach to deliver purposeful change, actionable insights and guaranteed results. We work across all industries and business functions to optimize profits in a compressed timeframe. AArete humanizes data by translating numbers into actionable insights, helping clients make better decisions and standing by their side to foster change with confidence, empathy and purpose. Learn more at AArete.com or follow us @AArete on LinkedIn & @aareteconsulting on Instagram.

About the Author

Leslie Lotano-Saba
AArete Managing Director
LLotano-Saba@AArete.com

Leslie Lotano-Saba is a pharmacist and healthcare executive with deep expertise in managed care, drug benefits strategy, and operational performance improvement. She has held senior leadership roles across health plans, PBMs, and clinical organizations, including serving as SVP of Pharmacy at Amerigroup, where she oversaw one of the nation's largest Medicaid pharmacy programs, and as VP of Pharmacy at Horizon NJ Health, where she led a successful PBM insourcing and launched award-winning disease management initiatives.

Leslie's strategic guidance has helped payer organizations navigate PBM relationships, optimize drug management programs, and reduce drug spend without compromising quality. She holds a Bachelor of Pharmacy from Albany College of Pharmacy, a Master's in Healthcare Administration from Union College (Clarkson University).

LEARN MORE ABOUT AARETE PHARMACY SOLUTIONS