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PHARMACY BENEFIT MANAGERS

Their Role, Impact, and the Need for Reform

Pharmacy Benefit Managers (PBMs) are powerful middlemen in the health care system that manage prescription drug benefits on behalf of insurers. While PBMs were originally created to streamline pharmacy benefits and help lower drug costs, their growing influence and lack of transparency have raised serious concerns about affordability, access, and fairness.

This resource is designed to help patients, providers, and health care advocates understand the role of PBMs, how they impact drug costs and access, and why reform is needed. It also explains how PBMs operate, the challenges they pose, proposed reforms, and where those reforms have been adopted across states.

What are PBMs?

PBMs are third-party companies hired by health insurers, employers, and government programs to manage prescription drug benefits.[1]

Why were PBMs created?

PBMs first became part of the prescription drug supply chain in the 1960s when private insurers began carving out prescription drug coverage as a separate benefit from general medical care.[2] At the time, insurers started relying on PBMs to handle a variety of administrative tasks from issuing prescription drug ID cards and electronic record keeping to larger responsibilities like processing pharmacy claims and managing prescription drug formularies.[3] While the role of PBMs was initially narrower, over the last few decades, prescription drug benefits have become more complex, resulting in PBMs taking on a much larger role.

What do PBMs do?

PBM's business practices have substantially evolved overtime and today, they conduct a variety of functions. Primary PBM responsibilities include:[4]

Negotiating rebates: Rebates are discounts provided by pharmaceutical manufacturers to PBMs to ensure a manufacturer's medication is included on a formulary. Rebates were originally designed to lower medication costs and incentivize pharmaceutical manufacturers to offer competitive and affordable pricing. However, in practice, these savings often don't reach payers or patients. Because rebates are calculated from a pharmaceutical manufacturer's list price, PBMs benefit more when list prices are higher, creating an incentive for PBMs to keep prescription drug costs elevated.

Developing formularies: A formulary is the list of prescription drugs an insurer agrees to cover, typically organized into different tiers. Lower-tier drugs usually come with lower cost-sharing, while higher-tier drugs require patients to pay more. PBMs determine which drugs appear on the formulary, which tiers drugs are placed on, and how much patients ultimately pay out of pocket.

Processing pharmacy claims: PBMs serve as intermediaries between pharmacies and insurance companies to ensure covered medications are paid for and approved in accordance with the plan terms and utilization management policies.

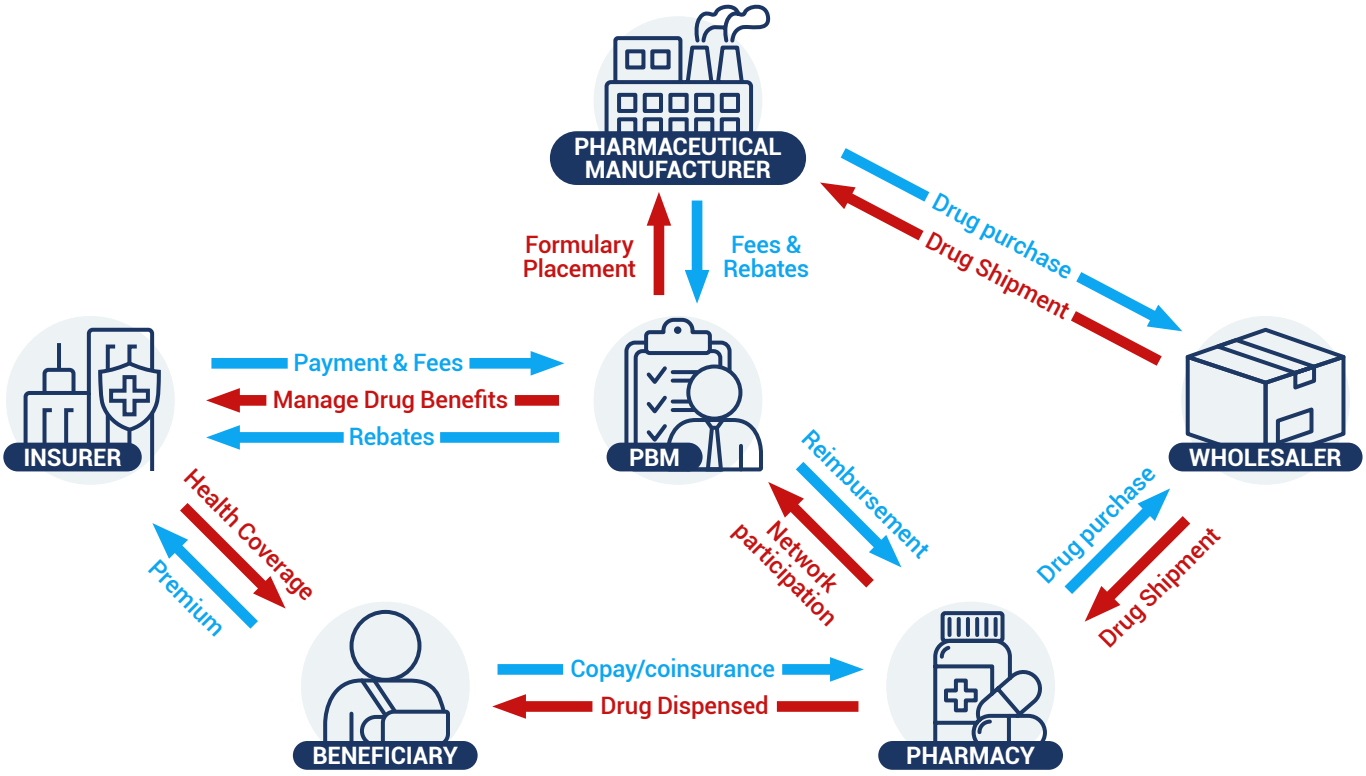
Managing pharmacy networks: PBMs determine which pharmacies beneficiaries can use to fill their prescriptions. These are known as "in-network" pharmacies. Some PBMs may also require the use of specialty or mail-order pharmacy services. In some cases, PBMs also own the pharmacy or mail-order pharmacy the beneficiary is required to use.

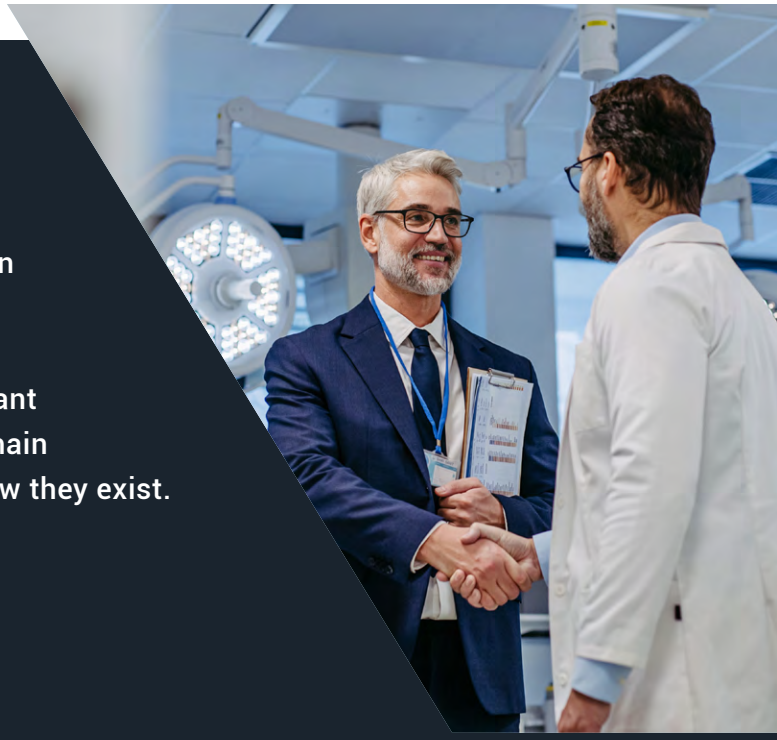
Why are PBMs commonly referred to as "middlemen" in the prescription drug supply chain?

PBMs are commonly referred to as "middlemen" because they sit between pharmaceutical manufacturers, health insurers, and pharmacies managing the flow of money, information, and services among them. For example:

1. After a pharmaceutical manufacturer receives FDA approval for a prescription drug, it sets a list price, the cost of the prescription drug before any discounts or rebates are applied. The pharmaceutical manufacturer then sells the drug in large quantities to a wholesaler, typically offering discounts or other negotiated concessions.[5]
2. After bulk purchasing, wholesalers sell the prescription drugs to pharmacies.[6]
3. Consumers visit their designated pharmacy to retrieve their prescription medication. To receive coverage for these medications, patients pay monthly premiums to their health plans, as well as copays or coinsurance at the pharmacy counter. Many assume these payments guarantee coverage for the medication their provider prescribes, but that is not always the case.
4. Health insurers hire PBMs to decide which drugs are included on their formularies. Because of this, some medications may be restricted or denied under utilization management tools such as step therapy, prior authorization, or non-medical switching.
5. PBMs often use formulary placement as leverage for pharmaceutical companies to offer more rebates or discounts. As a result, some pharmaceutical manufacturers that offer the best rebates and discounts often receive better placement on formularies. However, rebates are often structured to favor prescription drugs that deliver the highest financial return to the PBM, as PBMs often receive a percentage of the negotiated rebate which is based off a prescription drugs Wholesale Acquisition Cost ("WAC"). While PBMs may share a portion of the rebates with the health plan, they often retain a sizable share, incentivizing PBMs to prioritize prescription drugs with a higher WAC price to receive a better rebate return.
6. Finally, after the prescription drugs have been sold to the wholesaler, bought by the pharmacy and negotiated by the PBM, PBMs and pharmacies still have their own deal to make. To participate in an insurer's network, pharmacies must agree to certain set reimbursement rates and follow certain rules. PBMs then reimburse pharmacies for dispensing the drugs, but often at rates lower than the cost of acquisition for the pharmacy. As a result, pharmacies can lose money simply by filling prescriptions.

The graphic below provides an example of the complicated pharmaceutical supply chain and how PBMs connect multiple stakeholders in the supply chain.





Ultimately, despite controlling so many aspects of the prescription drug supply chain and process, PBMs never interact directly with patients. As shown in the above graphic, PBMs act as intermediaries working behind the scenes with manufacturers, wholesalers, and pharmacies. Despite their significant impact on patient access and drug costs, PBMs remain invisible to most patients, who often don't even know they exist.

Yet PBMs, decide:

- Which drugs are covered;
- How much patients pay out of pocket;
- Which pharmacies patients can use;
- Whether patients must try and fail on alternative drugs first; and
- Whether a health care provider's medical recommendation will be approved.

KEY ISSUES: Underscoring the Need for Reform

The following key issues illustrate how PBMs may be driving up costs, distorting incentives, and undermining patient access to affordable medications.

1. Transparency and Accountability

Problem: PBMs operate in a highly opaque system, controlling data on rebates, pharmacy payments, and fees charged to health plans while withholding critical information from regulators, payers, and patients. To fulfill their role, PBMs must work with multiple different stakeholders across different parts of the supply chain. Although they have access to much of the data these stakeholders use in decision making, other stakeholders and regulators often do not receive a fair exchange of information. It underscores the need for reform to ensure PBM practices are visible, accountable, and aligned with the interests of patients, payers, and the healthcare system as a whole.

Impact on Patients and the System: Patients, health plans, and policymakers cannot see the true costs of medications, limiting accountability and undermining trust. Without transparency, it is difficult to detect unfair pricing, inappropriate patient steering, or other practices that may inflate costs or restrict access to care.[7]

Potential Reform:

REFORM	EXPLANATION	STATES ENACTED
Require PBMs to obtain a license or register with the state	Mandates that PBMs register or obtain a license from the state before conducting business, allows states to monitor, investigate, and take enforcement actions against PBMs. It may also include requirements for regular renewal and disclosure of ownership, affiliations, and financial arrangements.[8]	34 states (AK, AL, AR, AZ, DE, FL, HI, ID, IL, IN, KS, LA, MD, ME, MI, MN, MT, NC, ND, NE, NH, NJ, NM, NY, OR, SC, SD, TN, UT, VA, VT, WA, WI, and WV).[9]
Mandate PBMs to report rebate or other information to the state	Requires PBMs to report key financial data, such as rebate amounts, drug prices, administrative fees, and other payments, to the state.[10] Requirements vary by state in terms of frequency, the specific agency receiving the data, and whether reporting is subject to audits or frequency of filings.[11]	27 states (AL, AR, CA, CO, CT, IA, ID, IN, KY, LA, MA, ME, MI, MN, MT, ND, NH, NJ, NM, NV, NY, OR, UT, VA, WA, WI, and WV).[12]
Require PBMs to report rebate or other information to health plans	Ensures that health plans have access to detailed information on the rebates PBMs negotiate with manufacturers, how much of those rebates the PBM retains, and what amounts are passed on to the insurer or patient, allowing payers to evaluate the value of their PBM contracts.[13]	11 states (AK, AL, CA, GA, ID, MA, MN, NY, SD, VT, and WV).[14]
Authorize insurers or regulators to audit PBMs	Ensures states have the authority to audit PBMs. Audit regulations may specify scope, frequency, and documentation requirements.	10 states (AL, AR, CT, IN, MI, PA, SD, TX, VA, and WI.)[15]

2. Fair Regulation of PBM Practices

Problem: PBM incentives are often misaligned with patient and plan interests. Practices such as spread pricing, rebate-driven formularies, utilization management, copay accumulators, and retroactive "clawbacks," may drive up costs, delay treatment, and restrict access to medically necessary medications.

Spread-Pricing: PBMs may charge health plans more for a prescription drug than reimburse the pharmacy that dispenses it. For example, a PBM reimburses a pharmacy $100 for a prescription drug but then charges the health plan $130 for the same drug, keeping the $30 difference, or "spread," as profit. This practice raises concerns about inflated drug costs, excessive PBM profits, and a misalignment of incentives that may not benefit patients or the healthcare system.[16]

Rebate-Driven Formularies: Rebates heavily influence which medications are included in formularies and at what cost-sharing levels.[17] When determining which prescription drugs to place on the formulary, PBMs consider clinical effectiveness and cost, but often prioritize prescription drugs that have the largest rebates given that PBMs often receive a percentage of the rebate.[18]

Utilization management: Restrictive policies like prior authorization, which requires a health care provider receive an approval from the plan before it will cover the prescribed medication, and step therapy policies, which requires patients to try and fail on alternative medications before the plan will cover the originally prescribed treatment, can delay care for patients, especially those with chronic or complex conditions, and may also discourage the use of generic drugs.[19]

Copay accumulators: Many PBMs and health plans also adopt copay accumulator programs, which apply third-party assistance toward a patient's immediate costs but exclude this assistance from counting towards their deductibles and annual limits on cost-sharing. As a result, consumers pay more out-of-pocket to reach their annual cost-sharing requirements.

Retroactive Clawbacks: PBMs are often responsible for administering benefits and determining which items and services are approved for coverage. However, PBMs can retroactively reduce payments to pharmacies and providers for previously approved claims, a practice known as a "clawbacks" or "retroactive denials."[20] For consumers, this can result in unexpected fees after they have received an item or service and reasonably believe it has been approved by the plan.

Impact on Patients and the System: These practices can cause patients to experience higher out-of-pocket costs, delays in starting medically necessary treatments, or require them to try and fail on less effective alternatives. In addition these practices may also contribute to health plans and the healthcare system overpaying for prescription drugs, and creating misaligned incentives that prioritize PBM profits over patient care.

REFORM	EXPLANATION	STATES ENACTED
Require rebate pass-throughs to plans/ patients	Require PBMs to pass all or a certain percentage of the rebates or other discounts received from manufacturers directly to plan sponsors or consumers, rather than retaining them as profit.[21]	9 states (AR, CO, GA, ID, IN, NH, PA, UT, and WV).[22]
Limit patient cost-sharing	Ensures patients can use manufacturer copay assistance without facing high out-of-pocket costs when it runs out by requiring these payments to count toward deductibles and out-of-pocket maximums.[23]	21 states (AZ, AR, CO, CT, DE, GA, IL, KY, LA, ME, NC, NM, NY, OK, OR, TN, TX, VA, VT, WA, and WV).[24]
Restrict white- and brown-bagging mandates	Bans white bagging and brown bagging, PBM practices that disrupt patient access to specialty medications by moving dispensing away from the patient's pharmacy.[25]	Brown bagging: 9 states (AR, DE, MN, ND, OH, OR, UT, VA, and VT).[26] White bagging: 11 (AK, DE, FL, GA, LA, MS, ND, OH, OR, RI, TX, and VT).[27]
Ban clawbacks/ retroactive denials	Prohibits most "clawbacks," except in limited cases like audits, by stopping PBMs from retroactively reducing payments to pharmacies and providers. This gives pharmacies greater payment certainty and protects patients from disruptions caused by financially unstable providers.[28]	22 states (AL, AR, CO, GA, IA, ID, IN, KY, LA, MD, ME, MI, MN, ND, OK, PA, SC, SD, UT, WA, WI, and WV).[29]
Limit or prohibit spread pricing	Prohibits PBMs from charging a health plan more for a drug than they reimburse the pharmacy, or requires disclosure of any retained difference, aligning PBM incentives with health plan goals and helping reduce costs for payers and employers.[30]	16 states (AR, CO, DE, FL, ID, IL, IN, LA, MD, MI, MN, UT, VA, VT, WA, and WV).[31]

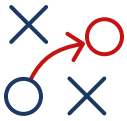
3. Promoting Competition and Preventing Market Abuse

Problem: The lack of PBM oversight has created a highly concentrated and vertically integrated market, giving a small number of PBMs broad control over pharmacies, healthcare services, and prescription drug costs. This market structure allows PBMs to steer patients toward their own affiliated pharmacies and services, even when independent providers may offer lower-cost or more personalized care.

Lack of Competition: The PBM market is highly concentrated, with the top three PBMs now managing 79% of all prescription drug claims for nearly 270 million people.[32] According to the Federal Trade Commission, when combined with the next three largest PBMs, the "Big 6" control 94% of the market.[33] Many PBMs are also vertically integrated with other stakeholders in the health care supply chain. This gives them broad control over the pharmaceutical supply chain, healthcare services, and costs, raising concerns about consolidation, self-dealing, and reduced competition.[34]

Vertical Integration: PBMs may reduce transparency by obscuring complex rebate agreements and pricing arrangements among PBMs, pharmacies, and insurers. This lack of transparency makes it difficult for patients, regulators, and payers to understand true drug costs or detect when patients are being steered toward higher-cost options.

Self-dealing: PBMs may steer patients toward affiliated pharmacies and services rather than local or independent providers, even when independent pharmacies offer lower-cost or more personalized care. For example, contracts and formularies can be structured to favor PBM-owned pharmacies by lowering copays or improving coverage, while imposing higher copays or stricter rules for medications filled at independent pharmacies. This reduces patient choice, limits competition, and increases patient out-of-pocket costs at non-affiliated pharmacies.[35]



Patient Steering: PBMs frequently direct, or mandate, patients to use specific pharmacies that are owned or affiliated with the PBM. They may limit coverage or offer lower out-of-pocket costs only if the patient fills prescriptions through a PBM-owned mail-order pharmacy, preferred or exclusive retail pharmacy. Patients using non-preferred pharmacies (such as an independent or another local option), may face higher copays or coinsurance, delayed or denied coverage, or the inability to fill the prescription at all. These tactics reduce patient choice, disrupt continuity of care, and harm independent pharmacies.[36]

Impact on Independent Pharmacies: Independent pharmacies are critical access points for care, especially in rural areas where large chain pharmacies may not operate.[37] PBM practices can threaten their viability by providing substantially lower reimbursement rates, refusing to reimburse or cover a prescription drug if it is filled at a non-affiliated or PBM-owned pharmacy, or imposing complex fees and audits that increase administrative burdens for small and independent pharmacies.[38]

Impact on Patients and the System: Patient choice is limited, and independent pharmacies may face financial instability or closure. Vertical integration and self-dealing reduce competition, increase costs, and obscure the true cost of medications, making it harder for patients, payers, and regulators to identify when higher-cost options are being imposed.

Potential Reform:

REFORM	EXPLANATION	STATES ENACTED
Prohibit patient steering to PBM-owned or affiliated pharmacies	Bans PBM steering, which limits patients to PBM-affiliated pharmacies through restrictive networks or financial incentives, raising costs and undermining independent pharmacies.[39] The reform protects patient choice and access to trusted community pharmacies without added costs or coverage limits.[40]	20 states (AL, AR, GA, IN, LA, MA, MD, MI, MN, MS, MT, NM, OK, OR, PA, SC, TN, TX, VA, and WV).[41]
Prohibit discrimination against non-affiliated pharmacies	Prohibits PBMs from offering better terms to affiliated pharmacies or refusing to contract with independent pharmacies, promoting a level playing field and ensuring patient access to local and independent pharmacies.[42]	24 states (AL, AR, CO, DE, GA, IA, IN, KY, LA, MD, MI, MN, ND, NM, PA, SC, SD, TN, TX, UT, VA, VT, WA, and WV).[43]
Establish pharmacy network adequacy requirements	Creates network standards, including travel distance (e.g., requiring non-urban networks to provide pharmacy access within 30 miles or 30 minutes[44]), health care provider ratios, and wait times, to protect patient choice, preserve rural access, and ensure fair competition, preventing PBMs or health plans from favoring mail-order or affiliated pharmacies and limiting patient access.[45]	8 states (ID, KY, ND, OR, PA, UT, VA and WA).

4. Protecting Independent Pharmacies and Patients

Problem: PBMs hold significant power over pharmacy contracts, often offering non-negotiable "take-it-or-leave-it" terms regarding rebate arrangements. Contracts may include gag clauses that prevent pharmacists from informing patients about lower-cost alternatives and impose complex audit and reimbursement requirements. These practices can be particularly harmful to independent pharmacies, which are critical access points in rural and underserved areas.

Contractual Power and Gag Clauses: PBMs hold significant power in pharmacy contracts, often offering "take-it-or-leave-it" contracts that dictate the reimbursement terms under which pharmacies must accept in order to remain in-network."[46] These contracts may also include "gag clauses", which prevent pharmacists from telling patients about lower-cost alternatives, such as paying cash instead of using insurance.

Reimbursement Rates: Pharmacies, particularly independent and rural ones, often receive reimbursement rates that do not cover their dispensing costs.[47]

Pharmacy Audits: PBMs routinely audit pharmacies to verify claims, but in some cases these audits are overly aggressive, based on minor clerical errors rather than fraud, and used to recover funds unfairly.[48]

Maximum Allowable Cost (MAC) Lists: MAC lists set the maximum amount a PBM will reimburse pharmacies for certain generic and multi-source drugs. Without oversight, PBMs can update these lists infrequently or without clear criteria, leaving pharmacies underpaid when prescription drug acquisition costs rise.

Impact on Patients and the System: Independent pharmacies may face financial instability or be forced to close, reducing patient access to care and lower cost pharmacies. Patients may experience treatment delays, disrupted continuity of care, or higher costs if PBMs favor affiliated or mail-order pharmacies. Administrative burdens on independent pharmacies can further reduce availability and quality of care.

Potential Reform:

REFORM	EXPLANATION	STATES ENACTED
Prohibit gag clauses on pharmacies that restrict pharmacy communication with patients	Bans PBMs from restricting pharmacists from telling patients about cheaper drug options,[49] with some reforms explicitly authorizing pharmacists to share this information with patients, ensuring transparency at the point of care.[50]	44 states ban gag clauses on pharmacies.[51] Under federal law, the 2018 Patient Right to Know Drug Prices Act[52] and Know the Lowest Price Act,[53] extend these protections to all patients, including those in Medicare Advantage and Part D plans. The 2021 Consolidated Appropriations Act (CAA) also closed gaps in employer-sponsored plans by banning gag clauses and requiring greater administrative transparency in prescription drug pricing.
Establish fair and transparent pharmacy reimbursement for pharmacies	Ensures fair pharmacy reimbursement by requiring PBMs to meet recognized benchmarks, providing an appeals process, and allowing state agencies, to set or adjust rates, preventing underpayment and supporting sustainability.	18 states (AL, AR, CO, GA, IA, KY, LA, MD, MO, NM, NY, OK, OR, TN, UT, VA, WA, and WV).[54]
Require PBMs to act in the best interest of health plans they serve	Imposes a legal "duty of good faith," requiring PBMs to act in the best interests of plans and enrollees, including preventing improper recoupments or reimbursement errors, and restoring any misused funds. Breaches can lead to liability or termination of PBM contracts, increasing accountability and trust in the health care system.[55]	5 states (CT, LA,[56] ME,[57] NY,[58] and VT[59]).
Regulate how PBMs conduct audits of pharmacies	Standardizes PBM's audit practices of pharmacies by limiting their scope and frequency, requiring advance notice, and guaranteeing pharmacies have the right to appeal audit findings.	9 states (AK, AZ, IN, MI, MN, NE, OK, WI, and WV).[60]
Establish requirements for PBM use of MAC lists	Requires PBMs to disclose how drugs are added to Maximum Allowable Cost (MAC) lists, which set the reimbursement caps for certain generic drugs, update the lists regularly, and provide an appeals process for pharmacies, promoting fairness and predictability in generic drug pricing.[61]	24 states (AK, AR, AZ, DE, GA, IA, ID, IL, IN, KS, LA, MD, ME, MI, MN, NE, NH, NM, OR, SC, SD, TX, VT, and WV).[62]

CONCLUSION

Over time, PBMs have developed into a complex and deeply embedded component of the healthcare system, often operating with limited oversight and accountability. Recognizing this, legislators and policymakers have acknowledged the need for comprehensive reform to address the systemic ambiguities and misaligned incentives within the industry. Enhancing transparency and accountability in PBM practices represents a critical step—among many—toward improving the overall affordability and effectiveness of healthcare for consumers.

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53. Know the Lowest Price Act of 2018, Pub. L. No. 115-262, § 2, 132 Stat. 3665 (2018).
54. National Academy for State Health Policy, *State Pharmacy Benefit Manager Legislation* (Oct. 2024); Iowa H.F. 2394, 90th Gen. Assemb., Reg. Sess. (2024); Mont. H.B. 740, 69th Leg., Reg. Sess. (2025).
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