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The Role of PBMs in the US Healthcare System

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Executive Summary

Pharmacy benefit managers (PBMs) administer prescription drug benefits to over 275 million people in the United States, supporting a variety of plan sponsors such as commercial health plans, self-insured employers, union plans, Medicare Part D, the Federal Employees Health Benefits Program (FEHBP), state government employee plans, and managed Medicaid plans.¹ In contract negotiations, plan sponsors and PBMs negotiate the services provided, ranging from administrative functions to clinical functions. Through formulary design, utilization management, and negotiations with pharmaceutical companies, PBMs exert significant influence on healthcare costs and health outcomes.

PBMs can support improved member health outcomes by offering clinical programs; however, the selection and implementation of these programs are ultimately determined by plan sponsors during contract negotiations. Research suggests that PBM-led member and clinician outreach programs impact medication adherence: up to 16% improvement for members with chronic disease.² Similarly, drug therapy management programs have helped members better manage chronic conditions and reduce their need for hospitalization, with one study reporting a 10.4% reduction in inpatient admissions and 2.6% reduction in emergency department utilization.³

Further, PBMs can generate cost savings for plan sponsors through negotiations with pharmaceutical companies and network pharmacies. The Government Accountability Office (GAO) found that PBMs helped plan sponsors manage drug benefits to offset Part D spending by 20%.⁴ A research paper from the National Bureau of Economic Research (NBER) estimates that PBMs generate at least \$145 billion in net annual savings for their plan sponsor clients.¹

Despite their widespread influence and integral function within the US healthcare system, PBMs have come under increased scrutiny from policymakers, regulators, and the general public. For example, the Federal Trade Commission (FTC) launched a 6(b) study into the PBM industry and filed suit against PBMs concerning insulin drug pricing. The FTC subsequently published a report in 2024, and a second interim report in 2025. PBM reform has also been a focus of Congress, with multiple bills currently pending in both the House and the Senate. At the state level, more than 30 legislatures have enacted at least one bill aimed to reform PBMs in the past two years, and there are at least a dozen states considering new restrictions to limit PBM practices.

This heightened attention stems from concerns raised by some policymakers and other stakeholders that PBM practices may contribute to rising drug costs and restricted access to medications. Additionally, critics argue that PBM consolidation has adversely affected the affordability and accessibility of medications. However, in a complex healthcare ecosystem, PBMs can play an important role to improve access and affordability of medications by keeping costs down for plan sponsors and their members.

Stakeholders may benefit from holistic assessments of proposed legislation or regulation of the PBM industry, to ensure plan sponsors and patients ultimately benefit, focusing on improving affordability and access through coordinated efforts across the pharmaceutical supply chain, including PBMs, manufacturers, payers, and regulators. Informed debate requires balancing the demand for transparency with an understanding of how PBMs can drive efficiency by promoting competition, reducing costs, and

improving adherence. Transparency efforts must be purposeful and targeted to ultimately provide real value to sponsors and consumers, avoiding unnecessary data complexities and costs.

This white paper describes the role of PBMs in the US healthcare system using evidence published in the literature to inform future discussions.

Methodology

To assess the evolving role of PBMs within the US healthcare landscape, we conducted a targeted literature review using PubMed as our primary database. We designed our search strategy to capture relevant publications focusing on various aspects of (1) PBM history and evolution context, (2) PBM impact on drug costs, access, and related health outcomes, and (3) emerging trends and future directions for PBMs. The initial literature search yielded 297 records through specific queries combining terms related to "Pharmacy Benefit Manager" or "PBM" with keywords such as "history," "cost effectiveness," "utilization management," "drug pricing," and "transparency," while excluding unrelated topics. We applied date filters to exclude articles from prior to 2014 (though included articles as far back as 2004 for the historical literature). Following rigorous screening processes based on relevance criteria aligned with our research objectives, 240 records were excluded leaving us with a final pool comprising 57 articles for further analysis. This process was conducted in parallel with review of the non-peer-reviewed literature using a similar search strategy. Within the identified evidence, we also employed a "snowball approach," scanning the citation lists for additional relevant articles. Through these steps we aligned on a prioritized list of 23 key peer reviewed and non-peer reviewed literature with insights into the history of PBMs and contemporary discussions surrounding the role of PBMs amid changing policies impacting US healthcare today.

Brief History of PBMs

PBMs play a pivotal role in the US healthcare system by administering prescription drug benefits. PBMs emerged in the late 1950s, initially in response to demand for specialized management of prescription drug benefits.⁵ The main function of early PBMs was processing claims and providing administrative support for health plans. Over time, their role has expanded to managing retail pharmacy networks, offering standard drug formularies, offering utilization management tools for plans to consider when designing a drug benefit, operating mail-order and specialty pharmacies, and negotiating with pharmaceutical manufacturers for rebates.⁵⁻⁷

In 1958, Prescription Services, Inc. was established by pharmacists in Canada, marking the beginnings of the PBM model. In the United States, PAID Prescriptions became the first recognized PBM in 1965.⁵ The 1974 Employee Retirement Income Security Act (ERISA) played a pivotal role in the growth of the industry by enabling large employers to utilize PBM services. This led to the expansion of PBMs from prepay plans to becoming an integral player in the US healthcare system. Throughout the 1970s and 1980s the PBM landscape experienced a wave of acquisitions and industry consolidation.⁵ This trend intensified in the 1990s, when pharmaceutical manufacturers began acquiring PBMs, further shaping the industry's structure. By the 2000s, ownership began to shift once again, moving from pharmaceutical manufacturers to national pharmacy chains and health plans. Today, no PBM is owned by a pharmaceutical manufacturer.^{5,8} In the 2010s, PBMs underwent yet another significant transformation through integration

with health insurers. These mergers, such as CVS Health’s acquisition of Aetna, and the Cigna acquisition of Express Scripts, reflect a broader shift toward centralized management of prescription drug benefits in the healthcare ecosystem.^{5,8} Figure 1 provides a timeline of key PBM activities since the 1950s.

Figure 1. Timeline of Key PBM Activities



Sources: ^{5,6}

Today, through contracts with commercial health plans, self-insured employer plans, union plans, Medicare Part D plans, state government employee plans, managed Medicaid programs, and the FEHBP, PBMs administer prescription drug benefits to over 275 million Americans.^{1,9}

Overview of PBM Services

PBMs offer a range of services for plan sponsors, encompassing both administrative and clinical functions, as outlined in Figure 2. For example, PBMs can negotiate reimbursement rates with participating network pharmacies, develop standard formulary offerings to plan sponsors, offer clinical tools to promote safe and cost-effective drug utilization, and negotiate with pharmaceutical manufacturers to secure rebates. The PBM and the plan sponsor agree on what services are to be provided during contract negotiations.

Figure 2. Range of Key Services PBMs Provide to their Clients



Prescription Drug Claim Processing

PBMs process prescription drug claims on behalf of plan sponsors as third-party administrators, providing the technology platform and staff needed to manage claims from end to end. This includes receiving claims from pharmacies or physicians; verifying member eligibility; adjudicating claims based on benefit configurations, state and federal regulations, and processing rules; managing requests for additional information and appeals; issuing payments; and transmitting explanations of benefits. Most of these activities occur at the pharmacy counter, so members know exactly what their out-of-pocket costs are when they pick up their prescriptions.

PBMs also monitor the process for efficiency and effectiveness, sharing regular—often daily—reporting to ensure service-level agreements are met. By automating and centralizing these functions, PBMs save employers time and reduce costs. Additionally, PBMs enhance patient safety by monitoring for drug-drug interactions, supporting drug utilization review (DUR), and flagging potential inappropriate prescribing patterns.

Pharmacy Network Development

PBMs negotiate terms with network pharmacies, determining payment conditions for inclusion in each sponsor’s network. Like provider network management benefits used in managed care, PBMs use this approach to foster competition among contracted pharmacies. Just as members save by visiting in-network physicians, they also benefit from lower costs when filling prescriptions at in-network pharmacies.^{5,10} PBMs’ network offerings typically ensure that members have access to a mix of local pharmacies, specialty pharmacies, and mail order pharmacies.⁵ PBMs also contract and develop adequate pharmacy networks that balance affordability and access, enabling plan sponsors to select participating pharmacies. Plan sponsors can further customize networks—such as narrowing or expanding pharmacy options—based on their budget and coverage goals, with the understanding that additional accommodations may come with higher costs.

Fraud, Waste, and Abuse Monitoring

PBMs actively monitor their contracts, claims, and pharmacy networks to identify potential fraud, waste, and abuse (FWA). This monitoring includes analyzing data for patterns or anomalies such as invalid claims, excessive or early refills, overprescribing by clinicians, and attempts by members to obtain duplicative prescriptions at multiple pharmacies (“pharmacy shopping”). These oversight activities promote patient safety and responsible stewardship of plan sponsor resources.

Formulary and Benefit Design

PBMs design formularies based on clinical evidence to optimize patient care through safe, appropriate, effective, and economic use of drugs.¹¹ Plan sponsors can adopt or modify these formularies or can customize their own formulary. Formularies include thousands of drugs across generic, branded, and specialty drugs across therapeutic classes. To create a formulary, the PBM leverages its Pharmacy and Therapeutics (P&T) Committee, which determines the most clinically appropriate drugs in class and indication and informs tier placement and utilization management tools. The P&T Committee is comprised of pharmacists, primary care physicians, specialists, and other clinicians. The P&T Committee meets on a regular basis to review clinical efficacy, safety, patient satisfaction, adherence, and convenience information to inform which medications are to be included in the formulary, on which tier, and to what level of coverage.¹⁰ Costs are evaluated after the clinical review and are used to consider formulary placement when there are multiple drugs available in a given class or for drugs that are optional on the formulary. PBMs can create a standard formulary and benefits offered to all plan sponsors, but often, PBMs maintain multiple formularies that are each tailored to the specifications and preferences of a particular plan sponsor.⁵ As part of formulary design, PBMs and plan sponsors also determine benefit structure, including copay and coinsurance.

Negotiations with Pharmaceutical Companies

Pharmaceutical companies set the list prices of their medicines. PBMs do not control these prices, but they do negotiate with pharmaceutical companies for placement of branded drugs on formularies in exchange for rebates and other price concessions. These negotiations drive down the net cost of branded drugs for plan sponsors and patients.

A rebate is a discount on the list price that is often paid by the pharmaceutical company back to the PBM on a periodic basis for the filled scripts of the rebated drug. Pharmaceutical companies provide rebates to PBMs based on a range of factors, including preferred formulary placement and market share performance. These rebates are typically reconciled and paid on a quarterly or annual basis. Negotiated rebates can be substantial—often ranging from 20% to over 40% of a branded drug’s list price.^{6,8} PBMs leverage their aggregated purchasing power across multiple plan sponsors to secure these discounts.

Most of the rebate dollars—90% to more than 95%—are passed through to plan sponsors, depending on how the plan sponsor elects to allocate rebates as set forth in the terms of the contract.^{6,12} These savings can be used to reduce premiums, lower out-of-pocket costs, or support broader benefit design strategies.

Utilization Management

Like managed health plans, PBMs use evidence-based utilization management techniques to manage healthcare resources. Utilization management programs are intended to review and assess the appropriateness, necessity, and efficiency of medical services and resources to optimize care, promote safety, and reduce costs. PBMs deploy these programs within accordance of the plan design developed at the direction of the plan sponsor. Some utilization management techniques include:

- **Prior Authorization:** Medications with prior authorization require prescribers to submit clinical evidence of therapeutic need for the PBM to provide approval prior to dispensing. Many medications that require prior authorization have generic alternatives, present risks of misuse or off-label use, or are high-cost specialty drugs. Prior authorization helps avoid the use of inappropriate or unnecessarily costly medications while also helping members avoid potentially dangerous medication combinations.¹⁰ PBMs may place prior authorization on a drug to confirm the diagnosis and treatment by the appropriate specialty provider.
- **Step Therapy:** Medications with step therapy require that prescribers explore a first-line, less expensive medication that is still clinically appropriate and efficacious before “stepping up” to the more expensive medication, per clinical guidelines. For example, consistent with clinical guidelines, PBMs may impose step therapy through disease-modifying antirheumatic drugs before a biologic is approved for a member with rheumatoid arthritis. Additionally, if there are multiple drugs in the same class with no clinical differentiation, a PBM may require the member to step through the preferred brand drug before moving to the non-preferred brand drug to promote affordability for members. Prescribers may request an exception to step therapy requirements if they believe that the first-line medication is not medically appropriate or could be harmful to the member.
- **Quantity Limits:** Medications with quantity limits restrict the number of doses dispensed within a given timeframe. Typically, this limit is consistent with FDA labeling to ensure safer access to medications and protect against inappropriate use and waste. For example, PBMs place quantity limits on certain drugs that are intended for short-term use only, like opioids for acute pain management or sedatives for insomnia.

Together, these utilization management tools are intended to reduce adverse drug events associated with multiple medications concurrently, reducing the potential for overuse and waste, while managing drug costs effectively.¹⁰

Safety Programs

PBMs offer programs that monitor for potential adverse events across all of a member’s prescriptions. Some common programs include:

Drug Utilization Review

PBMs use Drug Utilization Review (DUR) programs to monitor prescribing patterns, medication use, and outcomes to identify potential issues like drug interactions, inappropriate dosages, or therapeutic duplication within groups of patients. PBMs may monitor patients with certain conditions, such as asthma,

diabetes, or high blood pressure, or may monitor by drug-specific criteria such as therapeutic duplication, interactions, or contraindications. PBMs can deploy DUR programs prospectively, evaluating planned medications before they are dispensed, at the point-of-sale, alerting pharmacists at the time of dispensing, and retrospectively, after the medication has been dispensed. PBMs will leverage findings from DURs to implement interventions, such as prescriber education, hard or soft edits at the point-of-sale, or recommended changes to the formulary.

Drug-Drug Interactions

Since PBMs process all member pharmacy claims, they have a comprehensive view of the medications being filled by an individual member. Because a member could be seeing multiple physicians who may be prescribing different medications, the PBM often has a more complete and comprehensive view of the member as the processor of all the member's pharmacy claims than each individual physician has. PBMs monitor claims for potentially harmful drug interactions that were not identified by the prescriber or at the point-of-sale. When safety concerns arise, they then take prompt action such as notifying prescribers and members to avoid adverse events. This adds another layer of patient safety on top of alerts that are built into pharmacy point-of-sale systems.

High-Risk Drug Programs

PBMs offer safety monitoring programs to plan sponsors to examine the use of high-risk drug classes, such as controlled substances. These programs focus on ensuring safety, preventing misuse, and reducing fraud waste and abuse. PBMs monitor indicators such as polypharmacy (the regular use of multiple medications at the same time), provider shopping, and high claims or prescribing volume of high-risk medications. PBMs then investigate and address potential issues with prescribing physicians and members.

Clinical Programs

PBMs design clinical programs aimed at improving health outcomes, which are made available to plan sponsors for authorization. During contract negotiations, plan sponsors select which programs to implement for their members. Some common programs available through PBMs are listed below.

Adherence Programs

PBMs create programs for plan sponsors to improve member medication adherence in support of better health outcomes. Utilizing real-time data, PBMs identify patients at risk for non-adherence and tailor interventions to mitigate that risk. These interventions may include provider and member education on proper medication use, offering 90-day fill of certain medications to reduce frequency of refills, and providing mail order services to promote access.

Medication Reconciliation

PBMs offer medication reconciliation programs to ensure health and safety of members. In these programs, a clinician works with members and their healthcare providers to review and update medication lists for accuracy and to catch and resolve discrepancies such as omissions, duplications, incorrect doses, or potential drug interactions. The goals of these programs are to reduce the risk of adverse events and address any barriers to adherence.

Physician and Pharmacist Education

PBMs provide physician and pharmacist education programs, typically tailored around specific conditions or therapeutic classes, to help them support members in managing their health. These programs may include trainings, mailings, and phone consultations.

Care and Disease Management Programs

PBMs also offer care and disease management programs to assist members in managing chronic conditions. PBMs may offer digital formularies, remote monitoring programs, and engagement tools to support members managing chronic conditions. Further, PBMs typically provide real-time pharmacy data to health plans and plan sponsors to facilitate their care coordination efforts and care and disease management programs.¹⁰

Insights on Potential Impacts of PBMs from the Literature

Evidence suggests that PBMs have a positive impact on healthcare costs and health outcomes. The impact on costs is multifaceted through both direct and indirect savings. Direct cost savings can come from the negotiation process with manufacturers and pharmacies, and the indirect savings can come from improvements in health outcomes. This section outlines and summarizes current evidence from our targeted literature review on such potential impacts.

Findings on Potential PBM Impact on Costs

Much of the literature on PBMs explores the connection between the ability of PBMs to negotiate rebates and pass on savings to plan sponsors and patients. In many contracts, PBMs are able to extract large rebates from manufacturers, and are reported to often pass on 90% to 95% of rebates to the plan sponsor.^{6,12} The amount of rebate passed through to the plan sponsor and how those rebate dollars are used varies by contract and are negotiated between PBMs and plan sponsors during contracting.

Most of the rebates are passed on to plan sponsors, who in turn can choose to use those to offset premiums and slow the growth rate for prescription drug spending. Plan sponsors can also choose to pass them through directly to members. Regardless of the end use, the amount of rebate and how it is used varies from contract to contract and is dictated by the plan sponsor. While there is debate on whether drug rebates reduce prices, a GAO report found PBMs to be associated with reduced spending. The GAO found that in 2019, PBMs worked with plan sponsors to manage drug benefits, offsetting Part D spending by 20% (from \$145 billion to \$116 billion).⁴ These offsets through drug rebates can be associated with a significant reduction in out-of-pocket costs for patients. While the prices for prescription drugs have increased over time, rebates may act to dampen the increase; a study examining the wholesale acquisition cost between rebated and non-rebated

Research indicates that PBMs retained just 0.4% of rebates in Medicare Part D in 2019.⁴

drugs found that the price increased for rebated drugs by 13.9% and for non-rebated drugs by 15.6% in the same three-year period.¹⁴

Moreover, PBMs can generate savings through various management programs. For example, PBMs can use formulary management to encourage generic substitution. In generic substitution programs, members are switched from a branded drug to a generic drug when there is one available and no clinical difference between them.¹⁵

According to the 2024 annual report from the Association for Accessible Medicines, patients and the overall healthcare system saved \$445 billion in 2023 through using generics and biosimilars.¹⁵

These programs generate savings for both the patient and the overall healthcare system.

Additionally, PBMs can establish preferred pharmacy networks by requiring a higher quality standard at a lower reimbursement rate. An Avalere Health study found that the average monthly premium for plans with preferred networks was 17% lower than those without preferred networks.¹⁶

A research paper from the NBER estimates that PBMs generate at least \$145 billion in annual savings beyond their resource costs; these savings represent a net of \$168 billion in total benefits—including manufacturer rebates, the promotion of generics, and better drug utilization—and \$22 billion as resources used by PBMs in providing services.¹ The paper further suggests that requiring PBM services to be self-provided by plan sponsors would forgo approximately 40% of the net value due to increasing management costs.

Potential Efficiencies Introduced in Employer-Provided Pharmaceutical Coverage from the Literature

Employer-sponsored health insurance is the largest source of health coverage for non-elderly Americans, covering about 165 million individuals.¹⁷ Within the employer-sponsored insurance market there are a wide variety of arrangements: some employers outsource all their formulary and benefit creation to an insurer or third-party vendor, whereas others may take a more active role in design. Our literature review suggests that PBMs provide services that would otherwise need to be conducted by employer plan sponsors or a designated vendor, thus taking the costs and burdens of administration off each individual employer. PBMs provide the technology platforms that manage contract and claims administration. Further, PBMs can remove the administrative burden by administering pharmaceutical coverage for members (e.g., processing claims, developing and managing formularies, developing networks, and negotiating with drug manufacturers).¹⁸

PBMs can also help employers to limit unnecessary drug spending and promote transparency in pharmaceutical coverage. A 2023 survey of 50 employers¹⁹—each covering at least 1,000 lives and having more than \$1 million in annual prescription drug spend—found the following:

- 86% of employers choose to contract directly with a PBM for pharmacy benefits.
- Of employers working with PBMs, 48% were able to lower their costs by at least 5% through negotiations.
- 75% of employers considered their PBMs to be at least moderately transparent.

Health plans and plan sponsors often actively monitor contract performance and adjust their PBM contracts as needed. According to a 2024 survey conducted by the National Alliance of Healthcare Purchaser Coalitions, over the next 1–3 years, greater than 50% of purchasers surveyed intend to include transparent revenue disclosures, comprehensive rebate definitions, and more flexible formulary customization in future contracts with their PBMs.¹⁸ These results suggest that some purchasers regularly evaluate the perceived value of their contracts and turn to the market to seek changes in contracts.

Employers work with their PBMs to deploy strategies aimed to control costs (including out-of-pocket costs) and premiums.¹⁸ These strategies include promotion and inclusion of biosimilars on formularies, clarifying data ownership, including audit provision in contracts, using value-based contracting (VBC) strategies, and removing low-value drugs.

In 2024, employers reported the greatest reductions in premiums by deploying the following strategies in contract negotiation with PBMs¹⁸:

- **VBC formularies:** 27% net saw lower premiums
- **Defining “rebate” in contracts:** 24% net saw lower premiums
- **Disclosure of revenue streams with affiliated entities:** 15% net saw lower premiums
- **Flexibility to customize formulary:** 14% net saw lower premiums

Findings on Potential PBM Impacts on Health Outcomes from the Literature

Evidence showcases examples of how PBMs can also have a positive impact on health outcomes through the various evidence-based clinical programs offered to members, such as decreasing inpatient admissions and emergency department utilization.

For example, PBMs typically allow plan sponsors to offer automatic refill programs to improve adherence rates and reduce medication waste. A study evaluating an automatic medication refill program found that members enrolled in the program exhibited significant improvement in medication adherence across all therapeutic classes studied.²⁰

The medication possession ratio for members participating in an automatic refill program was 3 points higher for those receiving 30-day supply and 1.4 points higher for those receiving 90-day supply compared to non-participants. Members in the program also had greater than 2 fewer days’ oversupply than non-participants.²⁰

Additionally, PBMs can offer prescriber outreach programs to provide insights to prescribers and affect behavior change. One evaluation of a PBM’s mailing program found that mailings to physicians with non-adherent members on strategies to address barriers were associated with 11%, 16%, and 7% higher probability in members being adherent in antidiabetic, statin, and renin-angiotensin system (RAS) antagonist cohorts, respectively.²

Drug therapy management (DTM) programs can improve health outcomes by reducing high-cost care. For example, in a study evaluating a PBM DTM program—where pharmacists reviewed member profiles and made interventions along with care managers—researchers observed 10.4% lower inpatient admissions and a 2.6% decrease in emergency department utilization in the cohort.³

PBMs can also offer other clinical programs to improve members' chronic conditions. For example, a community pharmacist-driven PBM provided health coaching services to its members and found that the service reduced members' systolic blood pressures from 130.8 mm Hg to 125.7 mm Hg and diastolic blood pressures from 76.9 mm Hg to 73.7 mm Hg.²¹

Discussion on Recent PBM Reform Policies

The past couple of years have brought a flurry of both federal and state legislative activity around the regulation of PBMs. These regulations stem from concerns in the market around transparency and high prices in the pharmaceutical industry but fail to address some of the fundamental causes of these market failures. This section outlines some of the challenges and policies discussed in the public sphere.

Legislative proposals generally take the following forms:

- **Non-PBM affiliated pharmacy reimbursements** bills prohibit PBMs and issuers from discriminating against a pharmacy that a PBM is not affiliated with, for example by reimbursing a non-affiliated pharmacy an amount less for a drug than would have been reimbursed to an affiliated pharmacy for the same drug or service.
- **Patient cost sharing** bills dictate aspects of the methodology used by PBMs and issuers to determine patient cost-sharing amounts for prescription drugs. This section does not include rebate passthrough or copay cap bills.
- **Rebate pass through** bills require PBMs to pass on a specified percentage of rebates received to patients' cost-sharing amounts.
- **Spread pricing** bills prohibit PBMs from charging the issuer more than a drug's acquisition cost that the PBM paid to the pharmacy.
- **PBM reporting** bills include requirements on direct and indirect remuneration (DIR) fees, prescription cost, drug utilization, and reimbursement methodology.
- **White Bagging** bills prohibit PBMs and issuers from restricting a patient's coverage, reducing provider reimbursement, or requiring additional fees for covered clinician-administered drugs dispensed at an entity not selected by an issuer.
- **Delinking** bills require PBM compensation to be delinked from drug prices and be paid for a flat fee of services provided.

Federal Activities

PBM reform was a focus of the 118th Congress and has continued to be a focus of the 119th Congress. Key committees with healthcare and consumer protection jurisdictions have introduced bills addressing PBM business practices; there are at least 4 pending bills from the Senate and 16 pending bills from the House. These bills tend to focus on spread pricing (e.g. limiting the practice among PBMs), rebate retention (e.g. requiring 100% rebates to be passed through to plans), PBM compensation (e.g. delinking PBM compensation from drug prices), and transparency reporting (e.g. requiring PBMs to submit an annual report related to costs and spending). PBM reform bills in the Senate tend to focus on administrative fees,

spread pricing, and reporting requirements, while reform bills from the House largely focus on transparency and reporting requirements.

Each reform bill during the 118th Congress aimed to target at a different market, except *S.127 – PBM Transparency Act of 2023*, which aimed to target all markets. *S. 1339 - PBM Reform Act* targeted the commercial market, and *S. 2973 - Modernizing and Ensuring PBM Accountability Act* targeted Part D plans. The Senate Finance Committee released “A Bipartisan Framework for Reducing Prescription Drug Costs by Modernizing the Supply Chain and Ensuring Meaningful Relief at the Pharmacy Counter” that likely targeted the Medicare or Medicaid market specifically. In the 119th Congress, the Senate Finance Committee and Commerce Committee reintroduced bills on PBMs. *S.526 - Pharmacy Benefit Manager Transparency Act of 2025*, which requires PBMs to report to the FTC on spread pricing and pharmacy fees, and *S.527 - Prescription Pricing for the People Act of 2025* requires the FTC to complete a 6(b) study on PBMs. On the House side, *H.R.950 - Saving Seniors Money on Prescriptions Act* requires PBMs to disclose underlying cost performance measurements and provide an itemized list of prescription drugs dispensed.

In February 2025, the House Energy & Commerce Committee’s Health Subcommittee held a hearing entitled, “An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients.” This hearing was the first PBM-focused hearing of the 119th Congress, building on momentum from the previous session and reflective of ongoing bipartisan efforts to address PBM-related issues. Although PBM reforms (e.g., Medicaid spread pricing, Part D linking, transparency) were considered, they were ultimately not included in the December 2024 government funding bill. However, there is potential for these policies to be included in legislative packages in FY 2025.

Current scrutiny of PBMs stems in part from a report released by the Federal Trade Commission in 2024 as the result of a 6(b) study. The report discussed PBM business practices such as fees, clawbacks, pharmacy networks, reimbursement methods, manufacturer rebates, and formulary tiering rationale. As part of the study, the FTC released two interim reports, with the first addressing PBM impacts on accessibility and affordability of prescription drugs, and the second addressing PBM influence on specialty generic drugs.

State Activities

State policymakers also continue to consider bills that would establish oversight and reporting requirements for PBMs. As of April 10, at least 14 states (AL, AR, CT, IA, IL, MD, MS, MN, NC, NV, NY, OK, SC, RI) have introduced such legislation in 2025. Additionally, there are at least a dozen states with pending new restrictions.

Most recently, in April 2025, Arkansas Governor Sarah Huckabee Sanders (R-AR) signed *HB1150* into law, banning PBMs from owning pharmacies in the state. State attorneys general in 39 states signed an open letter urging Congress to enact similar restrictions. Figure 3 provides an overview of state legislative activity between 2023 and 2025 related to PBMs regulations in non-PBM affiliated pharmacy reimbursements, patient cost sharing, rebate pass through, spread pricing, PBM reporting, white bagging, and delinking.

term. Researchers suggest that, to address drug pricing issues on all levels, any policies aimed at regulating PBM practices should include the entire pharmaceutical supply chain and use a transparent approach for evaluation.²³

Conclusion

Although PBMs have the potential to play a valuable role in managing drug costs and driving competition, their influence on pricing and access has raised concerns in the face of growing cost pressures and evolving market incentives. However, PBMs are not the only entities with influence on price and access to drugs and evaluations of their role within the broader healthcare ecosystem should be viewed with a more comprehensive and evidence-driven approach.

PBMs are also not uniform entities; their roles vary based on the needs and services requested by the plan sponsor. They can serve as intermediaries, facilitating communication between stakeholders such as employers and manufacturers, or take on more active roles in clinical activities such as adherence and care management. Depending on the arrangement, they may function as passive third-party administrators, assisting plan sponsors with formulary execution and claims processing, or they may take a managed care approach, implementing programs to enhance patient safety and healthcare outcomes.

PBMs have tools to lower drug costs by reducing FWA, promoting competition, negotiating discounts, and encouraging use of generics when appropriate. PBMs collaborate with various stakeholders to design contractual relationships that reflect the sponsor's priorities. Health plans and plan sponsors, especially large and sophisticated actors, are generally experienced in negotiating terms that align with their goals for cost and care.

Although concerns about transparency persist, it is important to recognize that plan sponsors today have access to more transparent PBM models (e.g., pass-through or "clear" models). Still, many choose to retain traditional PBM structures to benefit from greater negotiating leverage and administrative support.¹⁰ Transparency alone does not guarantee affordability, and policies that narrowly target PBM practices may not strike the balance needed to preserve tools that support cost containment and appropriate medication use (e.g., formulary control, rebate management, and utilization restrictions).

As policymakers consider reforms, it is critical that regulatory efforts be grounded in a fair, evidence-based evaluation of the PBM role in the drug supply chain. PBMs have faced criticism from stakeholders such as pharmaceutical manufacturers and clinicians regarding their impact on access and pricing. While some critiques highlight legitimate concerns, the complexity of the drug supply chain makes it challenging to attribute outcomes to any one entity without comprehensive data. Without careful study, reforms risk unintended consequences that could increase costs for patients and payers by weakening key cost-containment strategies. Moving forward, policy discussions should be grounded in transparent, data-driven analyses that reflect the complexity of the pharmaceutical ecosystem and the shared responsibility of all stakeholders in influencing drug affordability and access.

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