Pharmacy Benefit Managers (PBMs)

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Overview

Pharmacy Benefit Managers (PBMs) represent a significant, yet often controversial, component of the health care and prescription drug supply chain.

Drug pricing in the United States is impacted by a variety of competing factors which often pose challenges for policymakers to decipher. Stakeholders within the prescription drug supply chain are faced with competing interests that are not structured to suit standardized pricing models. The lack of transparency around incentives and drug pricing methodology also complicates policymakers' efforts to reduce out-of-pocket costs for patients.

This primer provides a foundation for understanding PBMs, their core functions, their role in drug pricing and access, and the ongoing concerns driving reform, particularly within Michigan.

Key Points

- PBMs act as intermediaries between insurers, employers, pharmacies, and drug manufacturers in managing prescription drug coverage for patients.
- PBMs negotiate rebates and discounts with drug manufacturers, but the lack of transparency makes it unclear if savings reach patients.
- Critics argue PBMs' rebate system incentivizes higher list prices for prescription drugs, raising costs for patients who pay a share out-of-pocket.
- Supporters say PBMs reduce costs and streamline claims processing, but critics argue spread pricing and opaque contracts drive profits for PBMs.
- Michigan has enacted licensing, transparency, and anti–gag clause laws to regulate PBMs and protect consumers and pharmacies.
- Policymakers are exploring reforms such as rebate pass-throughs, bans on spread pricing, stronger oversight, and nonprofit PBM models.

Understanding Pharmacy Benefit Managers

PBMs are companies that function as intermediaries among health insurers, drug manufacturers, and pharmacies.[i] When they emerged in the 1960s, their focus was largely on claims processing functions, but they have since become influential negotiators within the U.S. health care system. The primary role of PBMs today is to manage prescription drug coverage on behalf of health insurers, employers, and government programs like Medicare and Medicaid.[ii]

PBM Operations and Stakeholders

Nearly all individuals with prescription drug coverage in the United States receive this benefit directly or indirectly through a PBM. Three major companies—CVS Caremark, Express Scripts (owned by Cigna), and OptumRx (owned

by UnitedHealth Group)—collectively control approximately 80% of the PBM market, giving them significant negotiating power.[iii]

PBM activities directly influence a diverse group of stakeholders including health insurers, employers, state agencies, pharmaceutical companies, pharmacists, and patients. The specific roles and relationships of PBMs are governed by complex contractual agreements, and each is described below in Table 1.

Table 1. Key stakeholders and their relationship to PBMs.

Stakeholder Type	Relationship to PBMs
Health insurers and employers	Rely on PBMs to administer prescription drug coverage and to help control costs.
Patients	PBMs work behind the scenes to make prescriptions affordable and accessible for patients, though some patients may encounter formulary exclusions[1] or elevated out-of-pocket costs.
Pharmacies	Contract with PBMs to join preferred networks with insurers. How much a pharmacy is paid for the medications they dispense is determined by PBMs. This can affect pharmacy viability, especially for independent and community pharmacies.
Pharmaceutical manufacturers	Negotiate rebate agreements with PBMs to secure favorable placement of their drugs on formularies.
State agencies	Oversee Medicaid and other public drug programs, often contracting with PBMs for management of prescription drug coverage.

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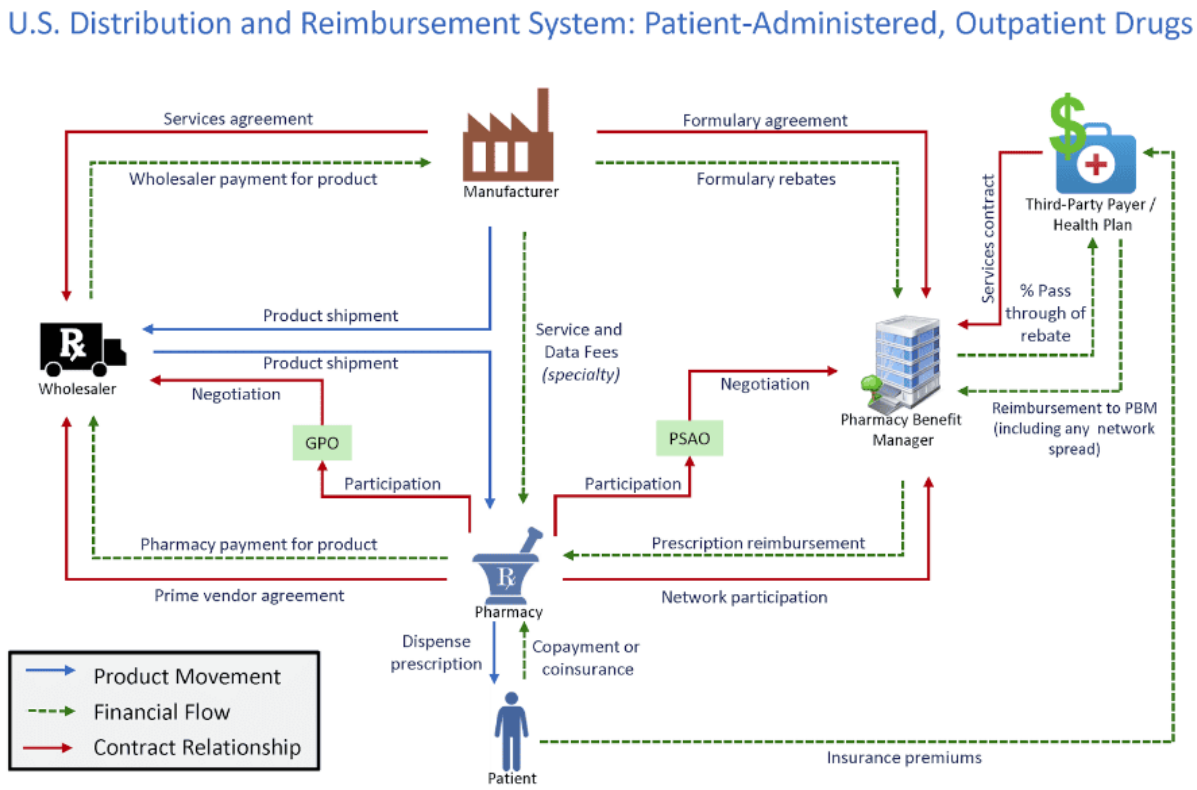
PBMs are positioned within the prescription drug supply chain, linking pharmaceutical manufacturers and wholesalers to pharmacies.[iv] (Figure 1) Although PBMs do not work directly with patients, they can impact availability of prescription medication, pricing, and in some cases, pharmacy viability. PBMs aim to control costs and streamline the delivery of prescription medication for both payers and patients, but their practices and impact on drug prices are the subject of ongoing policy debate.

[1] Formularies are lists of prescription drugs that are covered by insurance for a particular insurance plan. Formularies can limit coverage of certain drugs based on the insurer or employer benefit design.

Figure 1. Flowchart depicting the pharmaceutical drug supply chain.



GPO = Group Purchasing Organization; PSAO = Pharmacy Services Administrative Organization; DIR – Direct and indirect remuneration
Source: Fein, Adam J., The 2017 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers, Drug Channels Institute, 2017.

Core Functions of PBMs

PBMs perform a number of functions to support prescription drug coverage.[v] The core functions of PBMs are described in detail in Table 2.

Table 2. Core functions of PBMs.

Formulary design	Create and manage formularies (lists of medications) that are covered by health plans, often placing drugs into tiers based on cost and preferred status.
Negotiating rebates and discounts	Negotiate with drug manufacturers for rebates and discounts, leveraging the volume of prescriptions handled across their health plan clients.
Pharmacy networks	Establish networks of preferred pharmacies and negotiate the rates that pharmacies are paid for the medications they dispense.
Claims processing	Process prescription claims and manage payments between payers, pharmacies, and manufacturers.
Utilization management[vi]	Implement measures like prior authorization and step therapy[2] to control costs and encourage appropriate and cost-effective drug use.

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PBMs and Drug Pricing Dynamics

Drug pricing in the United States lacks transparency, with list prices determined by manufacturers but actual overall system costs are affected by PBM-negotiated rebates and discounts.[vii] PBMs leverage their scale to negotiate drug prices and rebates from drug manufacturers. The negotiated rebates, which are retained by the PBMs, are based on a drug's list price. Unfortunately, this arrangement can incentivize manufacturers to set higher list prices for drugs. Manufacturers may also raise prices to provide larger rebates to PBMs for preferred placement on formularies. Preferred status on formularies can lead to increased sales, prompting manufacturers to offer substantial rebates.

Perspectives on PBMs

Cost savings and operational efficiency:

PBMs and some economists assert that they lower costs for health insurers and employers by negotiating reduced drug pricing and implementing policies like tiered formularies, prior authorization requirements, and step therapies.[viii] They also claim to promote efficiencies for health plans and employers through centralizing claims processing and negotiating drug prices, reducing administrative burdens and simplifying the management of pharmacy insurance coverage.

Critics, including the Federal Trade Commission and the National Community Pharmacists Association, argue that a lack of transparency makes it difficult to know if savings are actually being passed through to health insurance payers and patients.[ix] PBMs are not required to disclose full details of rebate arrangements or pricing methodologies. The result is often spread pricing, where PBMs charge health plans one price for a prescription while reimbursing the pharmacy at a lower price, retaining the "spread" or difference as profit.[x] In addition, financial incentives–such as preferred status on a formulary–can push manufacturers to raise list prices, harming patients who pay a share of those prices out-of-pocket.

[2] Step therapy is a utilization management technique that requires patients to first try medications that are less expensive/generic options before their insurance plan will cover more expensive medications.

Appropriate medication utilization:

PBMs assert that they promote appropriate medication use through utilization management, ultimately saving money for patients and health insurers.[xi] This can be done by creating and managing formularies and step therapy to encourage the use of effective medications.

Critics, including the American Medical Association, argue that formulary placement is based on profit maximization for PBMs, rather than clinical evidence of effectiveness or cost savings for patients.[xii] Advocacy groups have raised concerns that PBM-driven restrictive policies (e.g., formulary exclusions, prior authorizations) can result in decreased access to needed pharmaceutical therapies.[xiii]

Impact on pharmacies:

PBMs assert that they help pharmacies by streamlining the claims process, negotiating lower drug prices with manufacturers, and facilitating patient access to medications through managed formularies.[xiv] They argue that their services enable pharmacies to participate in broader prescription networks, ultimately driving business efficiency and improving affordability for patients.

Critics, including pharmacy advocacy groups, argue that PBMs harm independent pharmacies by imposing lower reimbursement rates, applying retroactive fees, and steering patients toward PBM-owned or affiliated pharmacies.[xv] Through vertical integration, PBMs are more likely to be affiliated with or own pharmacies, insurance companies, and even health clinics.[xvi] These practices can undermine the financial sustainability of small, community-based pharmacies and limit patient choice.[xvii]

PBM Legislative Activity in Michigan

In 2022, Michigan lawmakers enacted a series of reforms designed to increase transparency, oversight, and accountability for PBMs operating in the state.[xviii] The new laws require PBMs to become licensed by state regulators, significantly enhance transparency through expanded reporting of pricing and rebate data, prohibit "gag clauses" that previously limited the information pharmacists could share with patients, set standards to protect independent and community pharmacies, and ban practices such as retroactive pharmacy payment reductions. Collectively, these measures position Michigan as a leader among states seeking to ensure fairer PBM practices and better protect consumers.

In addition to legislative initiatives, Michigan has taken legal action to challenge the practices of major PBMs. In April 2025, Michigan's Attorney General filed a lawsuit against Express Scripts and Prime Therapeutics—two of the nation's largest PBMs—alleging that the companies conspired to fix prices and allocate market share in violation of state antitrust laws.[xix] The complaint claims that Express Scripts and Prime Therapeutics colluded rather than competed in their negotiations with pharmacies, ultimately resulting in higher prices and fewer choices for Michigan consumers. The lawsuit also claims that these PBMs directly limited the ability of independent pharmacies to operate in the state.

Opportunities for PBM Reform

Transparency

At both the state and national level, policymakers are exploring a range of reforms aimed at addressing the concerns frequently raised about PBMs.[xx] One of the most common reform themes centers on transparency.[xxi] By requiring PBMs to disclose more detailed information about their rebate agreements, pricing structures, and the extent to which negotiated savings are actually passed on to insurers and patients, states hope to improve accountability and allow stakeholders to better understand how money flows through the prescription drug supply chain.

Regulatory oversight

Regulatory oversight has also become a central focus for reforms. Many states, including Michigan, have started to license PBMs and empower insurance departments or pharmacy boards to monitor PBM business practices. Greater regulatory authority allows states to set rules on how PBMs interact with pharmacies, negotiate with manufacturers, and structure contracts with health plans, which can help curb practices viewed as unfair or anticompetitive.[xxii]

Alternative PBM models

Some policymakers are considering structural reforms, such as supporting the development of public or nonprofit PBM models that would allow state agencies or coalitions of employers to negotiate directly with manufacturers–potentially bypassing the profit-drive incentives of commercial PBMs.[xxiii] These types of models may reduce administrative costs and ensure that savings are returned to payers and consumers.

Other policy changes

Other reforms include requirements for more of the rebates and cost savings negotiated by PBMs to be transparently and directly returned to the health plan sponsors or patients at the point of sale. For example, rebate pass-through mandates would prevent PBMs from retaining a significant portion of manufacturer discounts, which may help to align their incentives more closely with payers and patients. Bans on spread pricing–where PBMs keep the difference between what they charge health plans and what they pay pharmacies–are intended to make costs more predictable and equitable. Similarly, eliminating gag clauses empowers pharmacists to inform patients about the lowest-cost ways to purchase their medicines, improving transparency and consumer choice.

Conclusion

PBMs play a central, complicated role in the provision and pricing of prescription drugs in the United States. While PBMs have potential to control costs and promote efficient management of drug insurance coverage, questions about transparency, incentives, and patient outcomes ensure that PBM oversight will remain a priority for policymakers at the state and national levels.

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