



Why Savings Don't Materialize

THE TRUTH ABOUT PHARMACY BENEFIT PROCUREMENT

The Guide For
HR EXECUTIVES

.....
Bringing modern technology and service excellence to health plan
sponsors to reduce costs and deliver the level of care people deserve.

Health plan sponsors and other stakeholders responsible for pharmacy benefit programs have several new responsibilities under the Consolidated Appropriations Act of 2021, including a duty to ensure that the selection of vendors and other service providers is process-driven. So, there's no better time to keep that famous phrase, “**trust but verify**,” in mind.

But how can you be sure you achieve a fair and competitive contract for the most-accessed health care benefit: prescription drugs?

By seeking answers to several key questions:

- ✓ Why does it seem like the PBMs always have the upper hand in procurement and contracting?
- ✓ Why don't the savings I was promised during the request for proposal (RFP) ever seem to materialize?
- ✓ What can I do as a buyer to make sure my RFP (procurement process) yields predictable total pharmacy costs?
- ✓ What exactly goes into the “spreadsheet analysis,” and how does that yield a savings estimate?

We will explain the conflicting incentives and what the typical spreadsheet misses clinically. We'll also suggest key RFP-related questions throughout this eBook to help you achieve predictable drug pricing in your next RFP.

We'd love to hear from you if you have questions or would like to include Capital Rx in your next RFP!



Kristin Begley, PharmD
Chief Commercial Officer



Michael Miele, FSA, MAAA
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CONTENT SPOTLIGHT: [Self-Funded Plans Ignore the Consolidated Appropriations Act at their Peril](#)



The advantage traditional PBMs have had over their prospective & existing clients for decades is a result of a consolidation of market share and:

A broad imbalance of knowledge – PBMs have more information than plan sponsors and consultants, which gives them the upper hand in the procurement process. Unfortunately, most procurements **do not** capture the most impactful clinical management items influencing a payer’s total drug spend: formulary and clinical programs for each PBM.

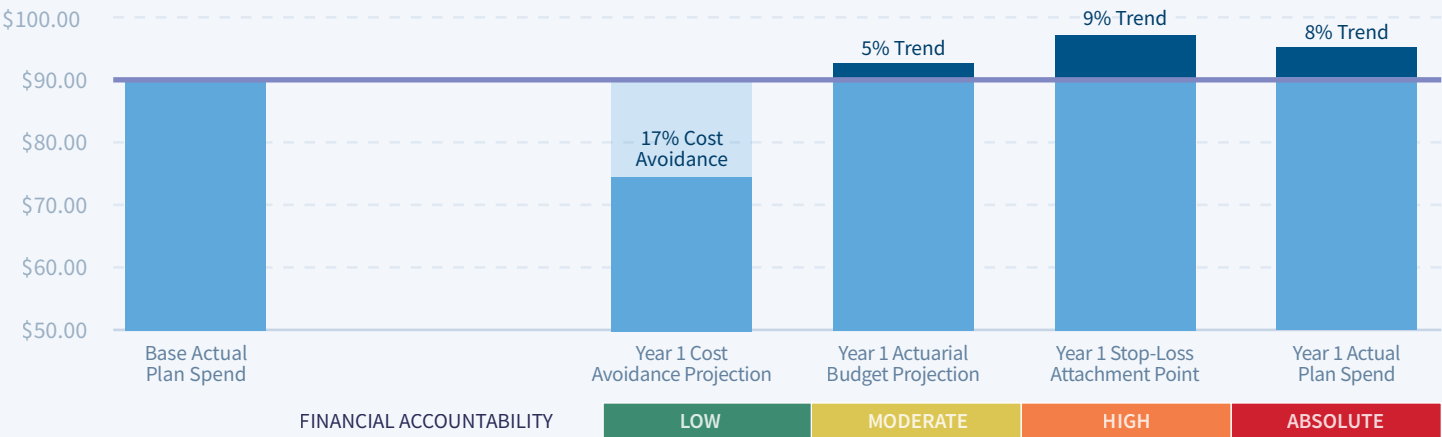
No “guarantees” on cost avoidance/projections – If you’ve ever been promised double-digit savings during the procurement process, you likely know that savings inevitably evaporate, leaving the plan sponsor who trusted the projections stuck with a positive cost trend year after year. Recent lawsuits against large employers highlight a) how easy it is to compare drug prices and find significant variances and b) that employer plan sponsors have a fiduciary obligation to their plan members. The standard PBM “offer” has limited financial risk because these bids are structured so that PBMs can meet “guarantees” even if total costs continue to rise for plan sponsors.

So, if procurement results suggest double-digit percentage “savings” on plan spend are achievable, it’s usually a good time to pause and take a step back. Be cautious if a PBM guarantees discounts and rebates on high-cost brand and specialty drugs, because the door is left wide open for excuses including “more specialty,” “more expensive brand utilization,” or “new-to-market drugs” are driving costs up.

PBMs have a tremendous impact on total plan spend through management of the formulary, refill cadence, and clinical programs, which ultimately drive per member per month (PMPM) cost for plan sponsors. Readers should note that we are defining PMPM cost as what the plan pays (all-in, net of claims costs, dispensing fees, admin fees, and rebates).

FIGURE 1
Rx Procurement Savings vs. Stakeholder Accountability

For illustrative purposes only, actual results may vary



What can plan sponsors do to bridge the knowledge gap?

Plan sponsors should include actuarial oversight in their procurement process. While it’s an added cost, a consulting actuary will likely tell you to expect a positive mid-single-digit trend (e.g., 5%). A stop loss vendor will be even more conservative than the actuaries and forecast an 8% - 10% trend, as that is what actual PMPM costs have demonstrated for most plan sponsors year-over-year. Unfortunately, most plan sponsors have come to accept this level of inflation as normal.¹

Why is there a disparity between the pharmacy RFP and actual results?

The devil is in the details of these complex procurement processes. Understanding how legacy PBMs make money can help put some power back in plan sponsors’ hands and highlight areas of potential conflict (e.g., if a PBM partner is retaining some portion of any revenue stream associated with the fulfillment of drugs for plan members, **then that value is not accruing to payers and their members**). And PBMs make money in more ways than most plan sponsors realize, including entering the businesses of repackaging and manufacturing drugs.²

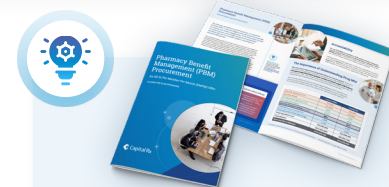
TABLE 1

	Profit Source	Method of Profit	Potential Conflicts / Risks
Admin Fees	Administrative Fees	Per claim or PEPM/PMPM service fees.	No obvious conflict.
	Clinical Program Fees	Fee structures vary widely. ROI is often misrepresented.	PBM can control the ROI calculations; are vendors URAC or NCQA accredited?
Retail Network	Retail Markup	PBM charges client more than they reimburse the retail pharmacy, resulting in “spread” margin.	Pricing concessions from retailers are pocketed by the PBM instead of flowing through to patients and plans.
	MAC Lists	PBM juggles clients across multiple MAC lists to game financial outcomes.	
	Network Fees & DIR	PBM charges retailers “participation fees” or quality performance penalties which are not disclosed or passed-through to the plan.	
Mail & Specialty	Mail Order Pharmacy	PBM dispenses drugs at a higher cost than they acquire them.	PBM has incentive to maximize the volume and the price of claims.
	Specialty Pharmacy	PBM dispenses expensive specialty drugs at a higher cost than they acquire them.	PBM steers members towards more expensive (i.e., more profitable) therapies.
Pharma Revenue	Rebates & Formulary Administrative Fees	PBM receives multiple revenue streams from pharma, sharing only a portion with the plan. Includes several rebate variants (formulary, market share, etc.).	PBM steers members towards more costly drugs that generate higher manufacturer payments.
	Clinical Program Funding	Pharma funds clinical management or adherence programs at a level that allows the PBM to retain profit beyond operational program costs.	Funding is opaque. Clinical programs steer members toward preferred products, which may be more costly.
	Inflation Protection Penalties	PBM penalizes pharma for price increases above a target inflation threshold, then retains some or all of the penalties.	Pricing concessions from pharma are pocketed by the PBM, and do not flow through to patients and plans.
	Data Sale Revenue	PBM aggregates and sells claims data to pharma for “market research”.	Details of data sharing are not disclosed to patients or plans.

It's been great to be a PBM for the last 20+ years.

As we mentioned, market share has consolidated and the sources of revenue have expanded. Plus, inflation works in the favor of PBMs and retailers, and demand for prescription drugs is inelastic – i.e., regardless of the price, patients need their medication.

Last, there's no “true price” in most PBM deals. PBMs generally provide guarantees for discounts, dispensing and administrative fees, and rebates, but these are based on a future mix of drugs that varies between PBMs and is rarely measured. The PBMs control the number of high cost brand and specialty drugs, which is the main driver of total plan spend or PMPM. Could you imagine a Director of Corporate Travel purchasing a fleet of cars for employees and making the decision based on the discount off manufacturer price and rebates, but not understanding whether they are buying an economy or luxury fleet of cars?



CONTENT SPOTLIGHT:

[PBM Procurement: A PMPM Guide for Plans Sponsors eBook | Capital Rx](#)

[PMPM - Is It the Best Way to Measure or Track Anything? | Capital Rx](#)

In our opinion, PMPM cost is the true cost, not discounts and rebates off an unknowable baseline.

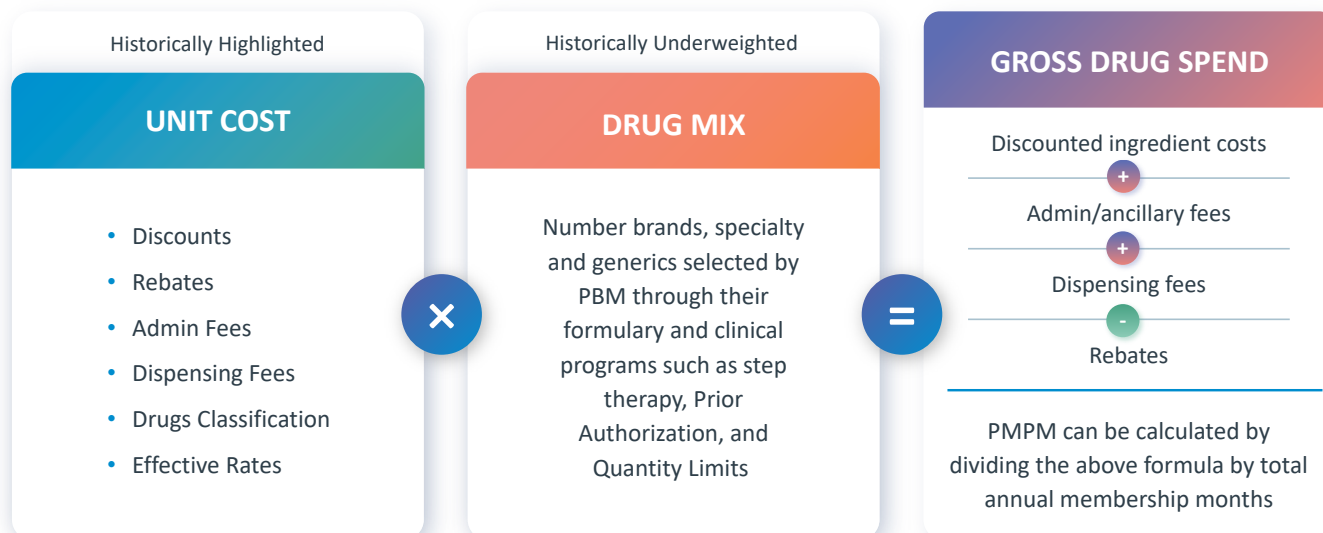
If a plan sponsor requires a PMPM deal, instead of the status quo discount and rebate “guarantees,” it would hold a PBM partner accountable to net cost and mitigate the risk of misaligned behavior, such as a PBM driving greater utilization to more expensive drugs.

Creating accountability on key cost drivers is essential when comparing PBMs' formularies, clinical program rigor, auto-refill protocols, and accounting for medication repackaged with new PBM-managed labels that have different starting prices. The two cost drivers that matter most in calculating total drug costs are:

Drug mix – This is the highest predictor of total plan drug spending and represents the types of drugs dispensed based on the formulary, clinical program approvals, and the number of pills shipped or refilled per person.

Unit cost – This represents how to classify a drug (e.g., brand, generic, or specialty) and how much each drug costs, inclusive of discounts, rebates, and administrative and dispensing fees.

FIGURE 2



Formulary and clinical program differences can easily add up to 12% to 23% of a plan’s total spend (net of rebates), but most spreadsheet models do not assess this. Also, considering that ~2% of drugs drive 50% or more of the average plan’s overall spend³ – a story we hear frequently – we think these drugs should be individually priced and guaranteed.

More time and attention should be spent evaluating the specialty drug list, formulary placement, and clinical program controls during the procurement process. These are the factors that ultimately drive the total costs for plan sponsors.

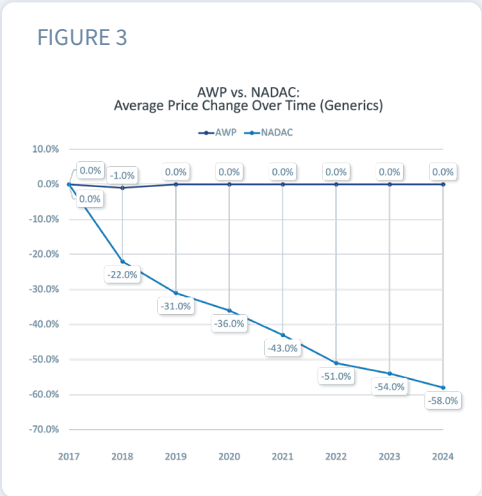
Use a Rational Price Index

The typical procurement process has primarily focused on measuring unit costs and ignored drug mix differences between PBMs.

Even today, procurement processes struggle to reflect the unit cost trend accurately. PBMs have been able to guarantee discounts and rebates off a baseline that has either trended slightly up because of inflation on average wholesale price (AWP) or does not deflate by anywhere near as much as an acquisition cost index like the national average drug acquisition cost (NADAC) index.

CONTENT SPOTLIGHT:

 [AH020 - Why NADAC is a “Ray of Sunshine,” with AJ Loiacono and Antonio Ciaccia](#)



Source: Capital Rx Analysis

We believe the procurement processes should weigh if a PBM is utilizing an arbitrary pricing index, and plan sponsors should seek an alternative to AWP.

TABLE 2

	Average Wholesale Price (AWP/MAC)	Medicaid /Acquisition Cost (NADAC)
Correlates to the actual cost of drugs?	✗	✓
Behaves the same for brands and generics?	✗	✓
Cannot be manipulated by Pharma/PBM?	✗	✓
Free and easily accessible?	✗	✓
Managed by an objective government entity?	✗	✓



Josh Golden
Senior Vice
President, Strategy

“NADAC represents the retailer’s true cost of acquiring the drug into inventory, which means that NADAC reflects the actual economics in the supply chain. When the real cost of a drug goes down, NADAC follows suit and deflates.”

Why Use NADAC-Based Pricing Over AWP
[READ THE BLOG](#) 

Rebates should be weighed, but not too heavily

Consider Table 3, which shows the impact of drug mix and rebates on total cost for a plan sponsor in two scenarios. Rebates matter, but a fair assessment of total rebate value is crucial to running an objective procurement process. All too often, payers will anchor decisions on the rebate value presented in the spreadsheet. But a plan receiving a higher dollar amount in rebates may not be better off because the large rebates come from the most expensive brand and specialty drugs.

An aligned PBM will usually help a plan sponsor realize a lower total cost due to a managed shift toward appropriate lower-cost alternatives. And remember, a PMPM guarantee from your potential PBM partner, will hold the PBM accountable for total spend and keep them aligned to your goals as a plan sponsor.

TABLE 3

	Legacy PBM	Aligned PBM (Measured Drug Mix)
Average Specialty Ingredient Cost per Drug	\$9,500	\$9,500
Average Specialty Rebate Payment per Drug	(\$4,180)	(\$3,800)
Nonspecialty Ingredient per Claim (All Drugs)	\$120	\$120
Nonspecialty Rebate per Drug (All Drugs)	(\$ 53)	(\$ 38)
Specialty Prior Authorization (PA) Approval Rates	90%	67%
Total PAs (Assume 3% of drugs require PA)	3,000	3,300
Total Approvals of Specialty Drugs	2,700	2,211
Total Ingredient Costs	\$27,968,000	\$20,849,180
Total Rebates	(\$12,147,784)	\$(8,185,672)
Total Cost Nets of Rebates	\$15,820,816	\$12,642,282

Assumptions used for illustrative purposes: 10K life group with 100,000 claims/year
>10% advantage given to Legacy PBMs on rebates

For plan sponsors that may prefer the status quo procurement, a word of caution:

Table 4 shows how typical rebate guarantees may be gamed to benefit a PBM, which could explain a portion of the year-over-year increase in plan costs that most plan sponsors experience. Don't worry, though. There is a way to deal with this without becoming a PBM attorney.

TABLE 4

Actual Rebate Yield Per Brand Claim:		\$284
One-step M.O.N.Y. Generic Definition	1% - 3%	\$293
LDD Claim Exclusion	2% - 4%	\$304
OTC Claim Exclusion	3% - 6%	\$321
340B Pharmacy Exclusion	2% - 4%	\$332
Rebate/Discount Offsetting	3% - 5%	\$346
25% Shared savings on coupon program	2% - 4%	\$358
180-Day Rebate Payment Terms	1% - 2%	\$364
Total Impact of All Tactics	14% - 28%	\$364

Assumptions used for illustrative purposes: 10K life group with 100,000 claims/year
>10% advantage given to Legacy PBMs on rebates

The key to measuring true rebates is forcing PBMs to provide rebates across all scripts; if a PBM is allowed to decide what a “rebatable” brand is, they will have the power to exclude certain drugs, and you’ll project artificially high numbers.

TABLE 5

	Per-Brand-Claim Guarantee (Gameplay)	vs.	Clear Per All Rx Guarantee
Guarantee to Plan Sponsor	~\$400/ 30 Day Retail ~\$3300/ Specialty		~\$65/Rx Guarantee* <i>*variable to Generic Dispensing Rate (GDR)</i>
Possible Exclusions	OTC, LDD, DAW, 340B, Test Strips, HIV, Low Day Supply, Vaccines, 100% Cost Share, etc.		340B, Vaccines
Estimated Annual Value to Plan	Variable & Unpredictable		Guaranteed & Predictable

Capital Rx Book of Business: 2024 Adjusted Claims and Gross Spend

TABLE 6

Drug Classification	Adjusted Claim Count Percent	Gross Spend Percent
Brand	13.4%	46.9%
Generic	85.4%	10.4%
Specialty	1.2%	42.7%

Paid and reversed claims submitted in 2023
Adjusted claim count weights claims with a days supply greater than 83 as 3 claims



Bridget Mulvenna
VP, National Business
Development

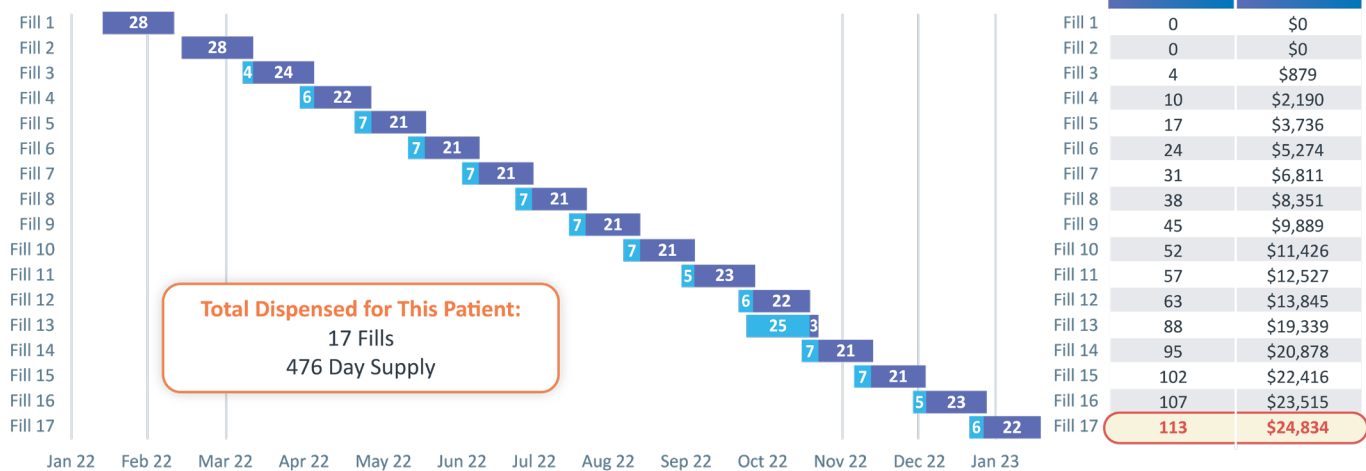
“Plan sponsors can break this addiction [to rebates] by prioritizing better formulary and clinical management and incentivizing members to use lower-cost drugs through reduced co-pays, for example. This will align plan sponsors with industry trends favoring transparency and cost management – a shift that will be accelerated by the ripple effects of the Inflation Reduction Act on commercial plans.”

Five Ways to Improve Your PBM Procurement Process in 2025
[READ THE BLOG](#) ➔

“Other” Cost Drivers

Plan sponsors should pay attention to some other factors that may influence total costs, such as newly repackaged drugs and auto-refill protocols. Newly repackaged medication can add another 3% to 5% to a payer’s cost, and the procurement process should evaluate whether a PBM promotes 15 months of therapy for chronic conditions vs. a more reasonable 13 months. Moving from a 75% refill threshold to 90% means that members would have approximately 30 days of excess medication at the end of the year vs. over 80 days of excess medication. Figure 4 demonstrates how auto-refill of a specialty drug can inflate costs for plan sponsors if a single member’s refills are “too soon.”

FIGURE 4



For illustrative purposes only

What else gives traditional PBMs an advantage?

PBMs have scale and vast resources. They have been able to maintain a position of power during the typical procurement process because they have better visibility around:

FIGURE 5

1

What drugs are coming to market, their costs, the rebates associated with them, and what utilization will look like (e.g., what the total population likely to use a new-to-market drug is)

Pipelines

2

What patent expirations are on the horizon, and how the generic manufacturers will react (i.e., PBMs know which drugs will lose rebates, how many competitors will enter the market with generics)

Patents

3

How all the little decisions made around prior authorization, formulary additions or deletions, etc., will impact plan costs.

Modeling

Leverage PMPM Guarantees to Improve the PBM Procurement Process

The best-case scenario is that plan sponsors with a large enough population – typically 4,000 lives or more - require all PBMs to bid PMPM guarantees, not AWP discounts and rebates where the total spend cannot be fully understood or compared on an apples-to-apples basis. This simplifies the procurement process so that a payer's chief financial officer, chief human resource officer, or chief executive officer can quickly do the math, know what's being spent per member or employee year-over-year, and evaluate it next to what they'll be paying next year.

How to Request a PMPM Bid

To request a PMPM bid from a PBM, payers must be able to provide the following:

- Two years of pharmacy claims data
- Associated invoices for the same time period of claims data
- Direction on plan design and clinical programs (status quo vs. enhancements to plan design coverage such as GLP-1s & weight loss not previously covered)
- An accurate estimate of membership, including details about any potentially meaningful changes

Do not let PBMs separate traditional (generic and brand) and specialty PMPMs, and clear targets should be defined with fees at risk for missing the mark. The fees should be dollar-for-dollar up to a certain threshold.

Clearly, the “easy button” is for payers to request that PBMs submit PMPM offers, which will incorporate the value of drug mix and units into one nice package while holding the PBM accountable for performance. If your potential PBM partner will not accommodate the request, do you want them as a partner? This has worked extremely well with fully insured Employer Group Welfare Plans (EGWPs), and real savings have been achieved with those programs.



“You don’t have to know what a brand or generic is because you’re getting a total cost guarantee. I truly believe PMPM is the easy button for everybody to understand something that’s been so complex.”

AH010 - The Power of PMPM: Holding PBMs Accountable for Total Drug Spend, with Kristin Begley, PharmD
LISTEN NOW 



What if a plan sponsor can't request a PMPM bid?

If you are a plan sponsor of a smaller plan and cannot request a PMPM guarantee, or you're not ready to change the status quo and simplify your next procurement process, you must have a plan to better measure and hold PBMs accountable to maintain or reduce your total spend. These are the key elements to improve the analysis and ensure your contract is worth the paper it's written on:

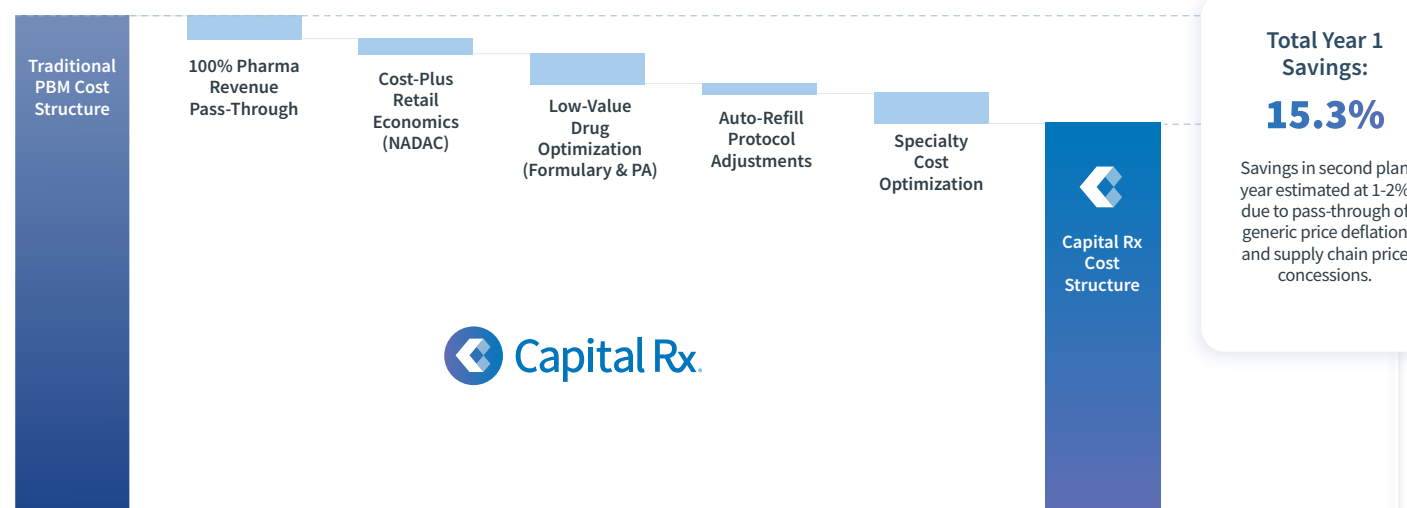
- 1. Drug mix** – include financial value on PBMs' different formularies and clinical programs, especially prior authorization.
- 2. Unit cost** – include a financial factor for inflation or deflation depending on if AWP or NADAC is utilized by the PBM. Check the financial valuation and assessment of the units of drugs filled per year (auto-refill programs on chronic medication) and look for unusual NDCs (repackaging by PBM-affiliated manufacturers, for example).
- 3. Consider having rebates provided across 100% of drugs** – with no exclusions, you do not have to hope all rebate exclusions are caught during procurement or contracting. The denominator across all claims leaves no room for interpretation at the end of the year.

Those three items will put the risk on the PBM and take the pressure off figuring out the next loophole or game that could impact your plan's cost trend. Now that you know what to look for and why, you can ask better questions and demand more of the PBMs you're considering partnering with to provide an essential benefit to your members.

If you ask us, a pharmacist and an actuary, both proud former consultants, "How have your clients done?" We're happy to share a picture that's worth 1,000 words.

V 5

Sources of Savings



*Savings results may be higher or lower based on market competitiveness of current contract and existing drug mix.

We'd also say, "There are some great consultants that are redefining procurement services to incorporate drug mix which ultimately allow plan sponsors meet their fiduciary obligation to employees."



Don't Assume All Parties Involved in Your RFP Have Aligned Incentives

If you're a health plan fiduciary responsible for managing a pharmacy benefit program, you can find trustworthy resources if you know where to look. Reach out to see how Capital Rx's team can be a resource and help make life easier ahead of your next RFP.



Additional Resources

[SoNE Health Testimonial](#)

[Replay: 5 Ways to Improve Your PBM Procurement Process In 2025](#)

[PBM Procurement: A PMPM Guide for Plans Sponsors eBook](#)

Contact Us To Learn More About How You Can Take Control of Your Pharmacy Benefit Program

¹ Business Group on Health. 2025 Employer Health Care Strategy Survey. August 2024. Available at: <https://www.business-grouphealth.org/resources/2025-Employer-Health-Care-Strategy-Survey-Intro>.

² HMP Omnimedia, LLC d/b/a Drug Channels Institute. What's Behind CVS Health's Novel Vertical Integration Strategy for Humira Biosimilars. September 2023. Available at: <https://www.drugchannels.net/2023/09/whats-behind-cvs-healths-novel-vertical.html>.

³ IQVIA Institute for Human Data Science. The Use of Medicines in the U.S. 2024: Usage and Spending Trends and Outlook to 2028. April 2024. Available from www.iqviainstitute.org.