

# Sample Employer, Inc. | Sample PBM, Inc.

Prepared for Board and Senior Leadership · PBMA, eff. 2026-01-01 · Analysis: May 10, 2026

## “ THE BOTTOM LINE

The current contract gives Sample Employer a clean exit and a neutral pharmacy network. It does not give Sample Employer the fiduciary commitment, the carve-out rights, or the rebate-scope clarity its board needs to demonstrate active oversight of a multi-million-dollar benefit.

### FIDUCIARY ALIGNMENT SCORE

61<sub>/100</sub>

FAIR

Sample Employer, Inc.'s PBM contract scored 61 out of 100 against the Contract X-Ray framework: **one provision in the Red Flag tier, two in Concern, five in Fair, and two in Good**. The score reflects a contract that clears a baseline standard and has clear room to lift on the provisions that matter most for board-level oversight.

This brief explains what the score means, why it matters under ERISA and CAA 2026, and the specific contract language changes available at the December 2026 renewal.

## THREE THINGS THE BOARD SHOULD KNOW

### FIDUCIARY POSTURE

**No behavioral commitment from the PBM.**

The agreement explicitly disclaims fiduciary status without an offsetting commitment to support the plan sponsor's obligations. The board has no contractual foundation for documenting active oversight.

### AUDIT ACCESS

**Narrow audit rights, but exercisable.**

Audit rights are present and exercisable, scoped to one annual review by a mutually-agreed firm. Restrictions include no extrapolation of findings, no aggregator-level access, and a defined sample-size limit. The plan sponsor can verify discrete claims but cannot pursue population-scale reconciliation of rebate flow.

### VENDOR OPTIONALITY

**A preferred-provider clause limits action.**

A repricing right kicks in if the plan engages a competing third-party vendor. The plan sponsor cannot freely use alternative funding programs or specialty carve-outs without risking financial penalty.

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# Why this matters

A PBM contract is one of the largest line items on your health plan budget.

The pharmacy benefit accounts for roughly a quarter of healthcare spend at most employers, and the PBM contract shapes every dollar of it: which drugs are covered, what the plan pays, what manufacturers pay back, and what Sample Employer, Inc. can verify.

Three things make this contract worth a closer look right now.

### COSTS ARE RISING

Pharmacy spending continues to outpace medical inflation. Without strong contract language, employers absorb list-price increases, rebate clawbacks, and undisclosed fees without recourse.

### BOARDS ARE ACCOUNTABLE

Federal law requires plan sponsors to demonstrate active oversight of plan service providers. This duty applies to the PBM contract itself. A well-negotiated contract gives leadership the tools it needs to monitor performance.

### DISCLOSURE RULES ARE TIGHTENING

Recent federal requirements (CAA 2026) obligate plan sponsors to verify, document, and report on pharmacy spending in ways older contracts make difficult. The contract is where this readiness either exists or doesn't.

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# What a strong PBM contract does

Ten things every well-negotiated contract handles.

A well-negotiated PBM contract supports the plan sponsor's responsibility to deliver the right drug, to the right participant, at the right price, with documentation sufficient to demonstrate to the board, the auditors, and federal regulators that the plan is being managed prudently.

We evaluate ten contract provisions, grouped into three categories.

### ACTS IN YOUR INTEREST

Three provisions about whether the PBM's incentives align with yours.

1. Does the contract acknowledge the plan sponsor's oversight role?
2. Does the PBM avoid steering decisions toward its own affiliates?
3. Does the formulary prefer the cheapest equally-effective drug?

### SHOWS THE MATH

Three provisions about whether you can see and verify what you're paying.

1. Are manufacturer payments passed through to the plan?
2. Are all rebates disclosed, on schedule, with no clawbacks?
3. Are administrative fees fully itemized and predictable?

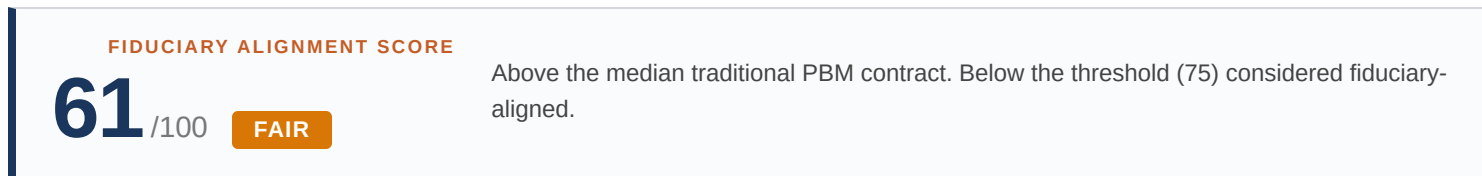
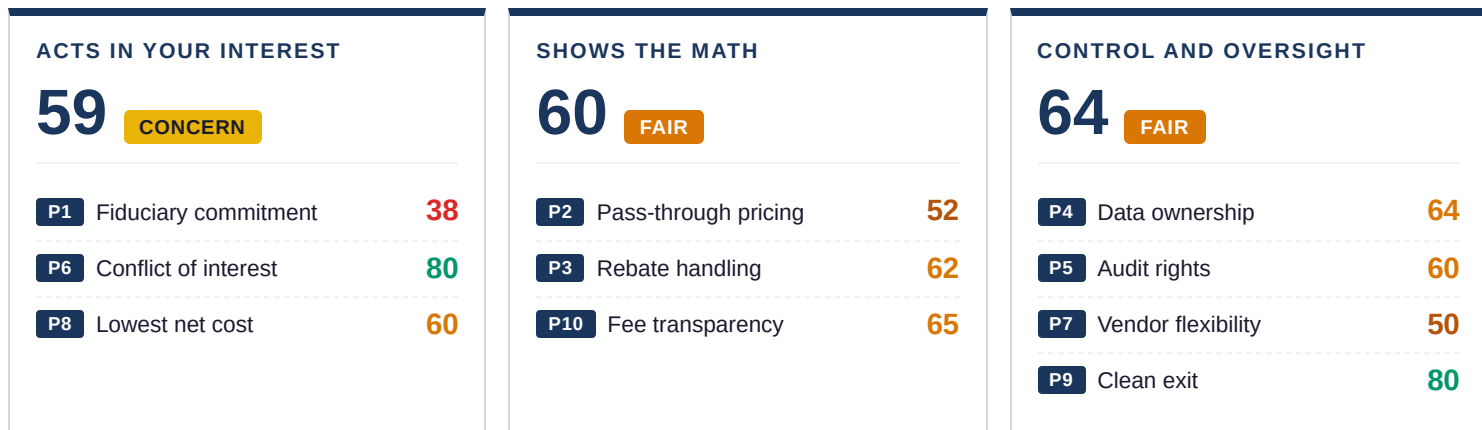
### CONTROL AND OVERSIGHT

Four provisions about whether you can monitor performance and exit if needed.

1. Do you own your claims data without restriction?
2. Can you audit the contract on your terms?
3. Can you use point solutions without economic penalty?
4. Can you transition to a new PBM cleanly if needed?

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# Where Sample Employer, Inc. stands



One provision scored below 45 (Red Flag). Seven scored 60 or above. The weakest area is alignment. The PBM's incentives may not consistently support the plan's.

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## What's at stake

Three areas where the current contract limits leadership's options.

### AREA 1 · MONEY YOU MAY BE LEAVING ON THE TABLE

- **Rebate scope excludes material PBM revenue:** The contract's Rebates definition covers amounts manufacturers label as rebates but explicitly excludes administrative fees, market development funds, and performance payments. These categories operate outside the 100% pass-through commitment. CAA 2026 disclosure obligations cover all forms of manufacturer compensation, not just amounts labeled as rebates.
- **Pricing transparency limited:** PBM-pharmacy economics are designated confidential under the contract. The plan sponsor sees the AWP discount it is invoiced but cannot verify what the PBM actually pays the dispensing pharmacy. The difference, if any, accrues to the PBM as undisclosed margin.
- **Specialty channel locked:** The preferred-provider clause in Section 2.3 restricts the plan from engaging third-party specialty pharmacies, alternative funding programs, or coupon optimization vendors without triggering a repricing right. Specialty drugs typically represent half of total pharmacy spend, and third-party programs in this category routinely produce 30 to 50 percent savings on individual drugs.
- **No book-of-business benchmark:** The contract includes no mechanism for benchmarking the plan's per-member-per-month costs against the PBM's book of business for similarly-sized clients. The plan sponsor has no contractual basis to test whether it is paying competitive rates relative to peers.

## AREA 2 · THINGS YOU CAN'T CURRENTLY VERIFY

- **Audit scope limits population-scale verification:** Audit rights are present and exercisable on an annual cadence, but cannot be extrapolated to the broader claims population and do not extend to the PBM's rebate aggregator or manufacturer contracts. The plan sponsor can verify discrete claims but cannot independently confirm rebate pass-through at the source where manufacturer compensation is committed.
- **Pass-through delivery is unverifiable:** The confidentiality of PBM-pharmacy pricing arrangements means the plan sponsor cannot test whether the pass-through commitment operates as written. The headline AWP discount may or may not reflect the actual cost paid to the dispensing pharmacy.
- **Manufacturer compensation completeness:** The contract discloses an administrative fee as the sole charge payable but does not provide an annual certification that no other revenue is derived from the plan relationship. Manufacturer administrative fees, adherence program payments, and supply chain margins may flow to the PBM outside the disclosed fee.
- **Aggregator and manufacturer contracts:** The audit right does not extend to contracts between the PBM, its rebate aggregator, and pharmaceutical manufacturers. Rebate verification at the source, where the manufacturer commits its compensation, is structurally beyond the plan sponsor's reach.

## AREA 3 · WHERE THE COMPANY MAY BE EXPOSED

- **ERISA fiduciary documentation:** Section 8.1 explicitly disclaims fiduciary status without an offsetting commitment to support the plan sponsor's ERISA obligations. The board has no contractual scaffolding for documenting active oversight of plan service providers under ERISA Section 404. In a DOL inquiry, the burden of proof for prudent oversight falls entirely on the plan sponsor without supporting documentation from the PBM.
- **CAA 2026 disclosure compliance:** CAA 2026 expanded plan sponsor obligations to obtain and review information sufficient to evaluate PBM compensation. The contract's confidentiality provisions on PBM-pharmacy economics, the narrow rebate definition, and the limited audit rights collectively constrain the disclosure the regulation requires. The compliance burden falls on the plan sponsor with the contract providing no mechanism to meet it.
- **Data ownership ambiguity:** The contract addresses data confidentiality consistent with HIPAA but is silent on plan sponsor ownership of claims data and unrestricted post-termination access. Ambiguity about ownership weakens the plan sponsor's leverage if a future transition becomes necessary, and leaves de-identified data derived from plan utilization contractually unrestricted.

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# What this is not about

Common questions about scope.

This analysis focuses on contract structure, not operational performance or vendor selection.

- **Service quality is separate.** This analysis evaluates contract structure, not operational performance. Sample PBM may be performing well operationally under an agreement structured to protect the PBM's economic interests more than the plan sponsor's. Member experience, claims accuracy, and call center responsiveness are different questions, separately measured.
- **The analysis reflects standards available today, not at signing.** The contract reflects market practice in place when it was negotiated. Standards have moved since then, particularly with CAA 2026 in effect. The gaps identified here are renewal opportunities, not historical failings.
- **Switching vendors may or may not be the right answer.** The decision to retain or replace the PBM depends on factors beyond the scope of this analysis: transition cost, current service performance, member impact, and what is achievable through the December 2026 renewal. This brief informs that decision but does not make it.
- **The right use of this analysis** is to enter the December 2026 renewal with a complete picture of what the current contract contains, what the fiduciary-aligned standard looks like, and which specific changes are worth pursuing at the negotiating table.

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## What to do next

Three or four steps in the next 90 days.

- 1** Review the Red Flag finding with ERISA counsel before the renewal window opens. Section 8.1 (fiduciary disclaimer) is the provision most likely to generate fiduciary documentation issues in a DOL inquiry. Counsel review now allows amendment language to be developed before the negotiation conversation, not during it.
- 2** Request a complete inventory of manufacturer payments retained by Sample PBM. CAA 2026 establishes this as a disclosure right. The inventory should cover administrative fees paid by manufacturers, market development funds, performance payments, and any other compensation associated with plan utilization. Knowing the scope of retained revenue is the first step toward closing the gap.
- 3** Authorize amendment scoping for the December 2026 renewal. The Red Flag finding (fiduciary support) should be designated as non-negotiable. Audit-scope expansion and the carve-out repricing trigger should be included as priority changes alongside five additional improvement opportunities. The advisor can prepare the redline package in advance of the negotiation conversation.
- 4** Quantify the financial exposure of the rebate carve-outs and spread pricing gap. The headline 100 percent pass-through commitment masks the exclusion of administrative fees, market development funds, and performance payments from the Rebates definition. Combined with the unmeasured pass-through delivery, the financial impact warrants baseline measurement before the renewal conversation.

**About this report.** This report is provided for informational and educational purposes only. It does not constitute legal, financial, or professional advice. Scores reflect explicit contract language. They do not evaluate business practices, marketing claims, regulatory filings, or operational performance outside the documents reviewed. Plan sponsors should consult qualified counsel before incorporating any model language into a binding agreement.

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