

# Sample Employer, Inc. | Sample PBM, Inc

PBMA, eff. 2026-01-01 · December 2026 · May 10, 2026

FIDUCIARY ALIGNMENT SCORE

**61** /100

FAIR

NEGOTIATION BRIEF

## A prioritized renewal playbook for the conversation with Sample PBM, Inc.

This report distills the contract's eight scoreable gaps into a prioritized renewal agenda. One is a Red Flag finding that compromises the plan sponsor's ability to demonstrate fiduciary oversight. Seven are Concern or Fair findings where contract language is incomplete. For each, this report supplies the current gap, the existing contract language, the fiduciary risk, model language to propose, and the talking points to bring to the negotiating table.

PRIORITY SUMMARY

#	Prov.	Rating	Issue	Score
1	P1	RED FLAG	<b>Fiduciary Loyalty Commitment</b> Section 8.1 explicitly disclaims fiduciary status without a behavioral commitment to support the plan sponsor's obligations.	38
2	P7	CONCERN	<b>Carve-Out &amp; Vendor Rights</b> Section 2.3 preferred-provider clause permits PBM to reprice guarantees if Sponsor engages a competing third-party vendor.	50
3	P2	CONCERN	<b>Pass-Through Pricing Integrity</b> AWP-discount pricing with no transparency into actual pharmacy reimbursement. Spread retention not addressed.	52
4	P5	FAIR	<b>Audit Rights &amp; Verification</b> Audit access is exercisable on an annual cadence but capped at one audit per year, scoped to mutually-agreed firms, and excludes extrapolation and aggregator access.	60
5	P8	FAIR	<b>Lowest Net Cost &amp; Clinical Integrity</b> Clinical efficacy and cost-effectiveness standard, but no explicit "lowest net cost" language. No PEPM benchmark.	60

WHAT'S INSIDE THIS REPORT

- Current contract gap by provision
- Fiduciary risk analysis
- Talking points for the conversation
- Citation to current language
- Model contract language to propose
- Before-signing checklist by category

**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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PRIORITY 1

P1

Fiduciary Loyalty Commitment

RED FLAG

38

GAP SUMMARY

Section 8.1 explicitly disclaims fiduciary status without a behavioral commitment to support the plan sponsor's obligations.

FIDUCIARY RISK

The plan sponsor has no contractual foundation to demonstrate active monitoring of plan service providers under ERISA Section 404. The contract leaves PBM with no obligation to cooperate with the plan sponsor's fiduciary review process, placing the entire burden of proof for prudent oversight on the plan sponsor without supporting documentation. CAA 2026 disclosure obligations require this level of cooperation as a practical matter; absence of contract language is a structural barrier.

CURRENT CONTRACT LANGUAGE

"Section 8.1: "PBM is not a fiduciary as that term is defined under ERISA. Nothing in this Agreement shall be construed to make PBM a fiduciary with respect to any Plan, the Plan Sponsor, or any Plan participant or beneficiary."

MODEL CONTRACT LANGUAGE

"PBM acknowledges that Sponsor has fiduciary obligations under ERISA with respect to the pharmacy benefit. PBM shall provide the data, transparency, and operational cooperation reasonably required for Sponsor to discharge those obligations, including but not limited to: complete claims-level data access, rebate pass-through verification, formulary decision documentation, and timely response to fiduciary inquiries. PBM shall maintain records sufficient to enable Sponsor's annual fiduciary review."

TALKING POINTS

- We are not asking the PBM to be a fiduciary. We are asking for contract language that supports our fiduciary obligations.
- CAA 2026 disclosure obligations require this level of cooperation as a practical matter. The contract should reflect it.
- Without this language, our board has no contractual hook to demonstrate active oversight in a DOL review.
- Every fiduciary-aligned PBM contract we have reviewed has equivalent language. This is industry standard now.

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PRIORITY 2

P7

## Carve-Out &amp; Vendor Rights

CONCERN

50

## GAP SUMMARY

Section 2.3 preferred-provider clause permits PBM to reprice guarantees if Sponsor engages a competing third-party vendor.

## FIDUCIARY RISK

The plan sponsor cannot exercise fiduciary judgment to engage best-in-class point solutions when doing so would reduce member cost. A repricing trigger keyed to third-party vendor engagement is a financial penalty disguised as a pricing adjustment. ERISA Section 404 exposure follows because the contract structurally discourages the plan sponsor from acting in participants' best interest where a third-party vendor would lower net cost.

## CURRENT CONTRACT LANGUAGE

*"Section 2.3: "If Sponsor engages a third-party vendor providing services substantially similar to those provided by PBM, PBM may reprice the financial guarantees set forth in Schedule B to reflect PBM's revised economics."*

## MODEL CONTRACT LANGUAGE

*"Sponsor reserves the right to engage third-party vendors for specialty pharmacy services, alternative funding programs, manufacturer coupon optimization, and clinical management services. Such engagement shall not constitute a breach of this Agreement and shall not trigger any repricing of financial guarantees. PBM shall coordinate in good faith with such vendors as reasonably required by Sponsor."*

## TALKING POINTS

- The preferred-provider clause prevents our plan from accessing market-leading alternative funding programs that routinely produce 30-50% specialty drug savings.
- We need explicit contractual permission to carve out without economic penalty. This is not about leaving the PBM, it is about preserving fiduciary optionality.
- Coupon optimization vendors are now standard practice. Restricting access to them is a structural barrier to lowest-net-cost outcomes.
- The repricing trigger in Section 2.3 is a financial penalty disguised as a pricing adjustment. Remove it.

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PRIORITY 3

P2

Pass-Through Pricing Integrity

CONCERN

52

GAP SUMMARY

AWP-discount pricing with no transparency into actual pharmacy reimbursement. Spread retention not addressed.

FIDUCIARY RISK

Without transparency into what PBM pays the dispensing pharmacy, the plan sponsor cannot verify whether the AWP discount reflects the actual cost paid to the pharmacy or whether PBM retains spread as undisclosed margin. CAA 2026 reaches this category directly: the plan sponsor must obtain disclosure sufficient to evaluate the economic arrangement, and a confidentiality carve-out for PBM-pharmacy pricing defeats that obligation.

CURRENT CONTRACT LANGUAGE

"Section 4.1: "PBM shall invoice Sponsor for each prescription claim at the applicable AWP discount rate set forth in Schedule B, plus the dispensing fee. PBM's economic arrangement with Network Pharmacies shall remain confidential."

MODEL CONTRACT LANGUAGE

"PBM shall pass through to Sponsor one hundred percent (100%) of the price PBM pays the dispensing pharmacy for each Plan claim. PBM shall not retain any difference between the amount invoiced to Sponsor and the amount paid to the dispensing pharmacy ('spread'). PBM shall make pharmacy reimbursement records available to Sponsor's auditor on request, subject to commercially reasonable confidentiality protections that do not impair audit verification."

TALKING POINTS

- Pass-through pricing means actual cost pass-through, not headline discount pass-through. The contract should reflect the actual standard.
- Spread pricing has been industry-standard PBM revenue. Eliminating it is the most material change available at this renewal.
- Confidentiality between PBM and pharmacy is reasonable. Confidentiality from the paying employer is not.
- CAA 2026 requires sponsor verification of PBM compensation. This provision is the verification mechanism.

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PRIORITY 4

P5

## Audit Rights & Verification

FAIR

# 60

**GAP SUMMARY**

Audit access is exercisable on an annual cadence but capped at one audit per year, scoped to mutually-agreed firms, and excludes extrapolation and aggregator access.

**FIDUCIARY RISK**

The plan sponsor can verify discrete claims but cannot independently confirm rebate pass-through, pricing guarantees, or formulary compliance at population scale. ERISA Section 404 requires prudent monitoring of plan service providers; CAA 2026 sharpens the disclosure-verification obligation. Without extrapolation and aggregator access, the plan sponsor can identify discrepancies but cannot recover at scale, and cannot reach the source where manufacturer compensation is committed.

**CURRENT CONTRACT LANGUAGE**

*"Section 9.4: "Sponsor may conduct one (1) audit per Contract Year. The auditor shall be a qualified independent firm selected by mutual agreement of the parties. Audit findings shall apply only to the specific claims reviewed and shall not be extrapolated to the broader claims population. PBM shall not be required to provide access to contracts between PBM and its rebate aggregator or pharmaceutical manufacturers."*

**MODEL CONTRACT LANGUAGE**

*"Sponsor may conduct up to two (2) audits per Contract Year through any independent auditor of Sponsor's selection. PBM shall provide reasonable access to all claims data, pricing files, rebate accruals, and manufacturer agreements relevant to the audit scope, including contracts between PBM and its rebate aggregator. Audit findings may be extrapolated to the full claims population using standard audit statistical methods. PBM shall remediate any identified financial discrepancies within thirty (30) days of audit completion."*

**TALKING POINTS**

- The audit right exists, but the restrictions mean we find errors without recovering at scale. That is not a meaningful right.
- Mutual agreement on auditor selection has become firm-of-Sponsor's-choice in the fiduciary-aligned standard. Two audits per year is the new norm.
- Aggregator-level visibility is where the manufacturer commitment actually lives. Without it, rebate pass-through verification stops at the PBM, not the source.
- These three changes (Sponsor's choice, extrapolation, aggregator access) lift this provision from DSI Bronze floor to DSI Silver floor.

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PRIORITY 5

P8

## Lowest Net Cost & Clinical Integrity

FAIR

# 60

**GAP SUMMARY**

Clinical efficacy and cost-effectiveness standard, but no explicit "lowest net cost" language. No PEPM benchmark.

**FIDUCIARY RISK**

Without explicit lowest-net-cost language, the formulary can favor higher-rebate drugs where clinical equivalence exists. This is a subtle but material fiduciary issue: members pay more in copays because the formulary prefers rebate-generating drugs over equally effective lower-list-price alternatives, while the plan sponsor cannot point to contract language that requires net-cost optimization.

**CURRENT CONTRACT LANGUAGE**

*"Section 3.4: "PBM shall maintain a formulary based on clinical efficacy, safety, and appropriateness for Plan members. Formulary decisions shall be made by PBM's Pharmacy & Therapeutics committee in accordance with PBM's clinical guidelines."*

**MODEL CONTRACT LANGUAGE**

*"PBM shall maintain a formulary designed to optimize the combination of clinical efficacy, safety, and lowest net cost to the Plan. Where therapeutically equivalent alternatives exist, PBM shall preference the alternative with the lowest net cost to the Plan and members. PBM shall provide annual documentation of the lowest-net-cost analysis applied to each tier-changing formulary decision."*

**TALKING POINTS**

- Clinical efficacy alone is incomplete. We need clinical efficacy plus lowest net cost.
- Where equivalent drugs exist, the formulary should pick the lower-cost one. This should not be controversial.
- Annual documentation of the lowest-net-cost analysis lets us verify the formulary is structurally aligned with our interest.
- This protects members from rebate-optimized formulary placements that drive higher out-of-pocket costs.

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PRIORITY 6

P3

## Rebate &amp; Manufacturer Revenue

FAIR

62

## GAP SUMMARY

Rebate pass-through carves out administrative fees, market development funds, and performance payments. The 100% pass-through applies only to amounts the contract defines as "Rebates."

## FIDUCIARY RISK

Material PBM revenue streams operate outside the pass-through commitment. The plan sponsor sees amounts that match the contractual Rebates definition but cannot demonstrate that all manufacturer payments flow through. CAA 2026 disclosure obligations cover all forms of compensation, not just amounts the PBM labels as rebates.

## CURRENT CONTRACT LANGUAGE

*"Section 5.2: "PBM shall pass through to Sponsor one hundred percent (100%) of Rebates earned on Plan claims. For purposes of this Agreement, 'Rebates' means amounts paid by manufacturers to PBM specifically designated as rebates, and shall not include administrative fees, market development funds, performance payments, or other manufacturer remuneration."*

## MODEL CONTRACT LANGUAGE

*"PBM shall pass through to Sponsor one hundred percent (100%) of all manufacturer payments earned on Plan claims, including but not limited to: rebates, administrative fees, market development funds, formulary access fees, performance payments, and any other direct or indirect remuneration received from manufacturers or distributors associated with Plan utilization."*

## TALKING POINTS

- The pass-through commitment is good but the Rebates definition is narrow. We need full manufacturer-payment pass-through.
- Administrative fees and market development funds are not rebates in industry usage, but they are economic returns the manufacturer pays to the PBM tied to our utilization. They should flow to us.
- CAA 2026 obligates us to verify all PBM compensation. A narrow Rebates definition prevents us from doing that.
- Every fiduciary-aligned contract we benchmark against uses a comprehensive manufacturer-payment definition. This is the current standard.

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PRIORITY 7

P4

Data Ownership & Rights

FAIR

64

GAP SUMMARY

Contract addresses data confidentiality consistent with HIPAA but is silent on plan sponsor ownership of claims data, unrestricted access in industry-standard formats, and treatment of de-identified data.

FIDUCIARY RISK

Without explicit ownership, the plan sponsor's data position is unsettled. Ambiguity weakens leverage if a transition becomes necessary, and the PBM has no contractual restriction on monetizing de-identified data derived from plan utilization. The plan sponsor underwrites the claims experience that creates the data asset and receives no contractual protection of its interest in that asset.

CURRENT CONTRACT LANGUAGE

*"Section 12.4: "All Protected Health Information shall be handled in accordance with the parties' Business Associate Agreement. PBM shall use Sponsor data solely as necessary to provide services under this Agreement."*

MODEL CONTRACT LANGUAGE

*"All claims data, utilization data, eligibility data, and member information shall remain the sole property of Sponsor. Sponsor shall have unrestricted access to all such data in industry-standard formats at no additional charge, in real-time or near-real-time, during the term of this Agreement and post-termination. PBM shall not sell, license, transfer, or monetize Plan data, including de-identified or aggregated derivatives thereof, without Sponsor's prior written consent."*

TALKING POINTS

- Plan sponsor ownership of claims data is a 2026 contract baseline. Silence in the existing contract is a gap, not a position.
- The de-identified data carve-out at most PBMs lets them commercialize claims-derived analytics without compensating the employer. That has real economic value.
- Unrestricted access in industry-standard formats supports both ongoing fiduciary monitoring and the practical mechanics of a future transition.
- This is also a CAA 2026 disclosure issue: we cannot verify what we cannot access.

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PRIORITY 8

P10

Administrative Fee Transparency

FAIR

65

GAP SUMMARY

Administrative fees are disclosed as a single PMPM amount. No sole-revenue certification. No book-of-business benchmarking.

FIDUCIARY RISK

Without a sole-revenue certification, the plan sponsor cannot verify whether the disclosed admin fee captures all PBM compensation from the relationship. Manufacturer administrative fees, adherence program fees, and supply chain margins may operate outside the disclosed fee. Under ERISA Section 408(b)(2) and CAA 2026, the plan sponsor must obtain disclosure of all direct and indirect compensation flowing to its service providers.

CURRENT CONTRACT LANGUAGE

"Section 6.1: "Sponsor shall pay PBM a per-member-per-month administrative fee as set forth in Schedule B. The Administrative Fee is the sole charge payable by Sponsor to PBM for the services provided hereunder."

MODEL CONTRACT LANGUAGE

"PBM shall provide annual certification that no other revenue, in any form, is derived from the Plan relationship beyond the fee categories disclosed in this Agreement and exhibits hereto. The certification shall extend to manufacturer administrative fees, adherence program fees, purchase discounts on PBM-affiliated dispensing, and any other compensation received from third parties associated with Plan utilization. PBM shall benchmark its fees annually against PBM's book of business for similarly-sized clients."

TALKING POINTS

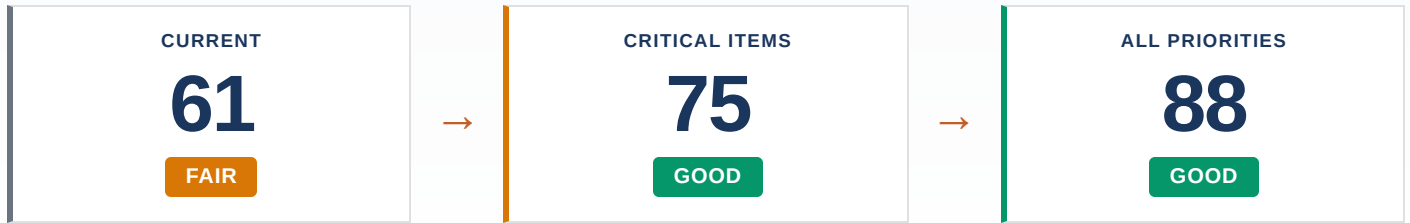
- The 'sole charge' language addresses what we pay PBM directly. It does not address what manufacturers pay PBM tied to our utilization.
- An annual sole-revenue certification costs the PBM nothing if the disclosure is complete. If it isn't complete, the certification surfaces it.
- Book-of-business benchmarking gives both parties a discipline mechanism. We expect to be in a defensible range. We want to see the range.
- CAA 2026 Section 408(b)(2) requires comprehensive compensation disclosure. This provision is how we operationalize it.

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PATH TO IMPROVEMENT

From current score to projected outcome.



Addressing the one Red Flag item lifts the contract to 75 (Good). Completing all priorities reaches 88 (Good).

BEFORE-SIGNING CHECKLIST

NON-NEGOTIABLE <span>3</span>	IMPORTANT <span>6</span>	RECOMMENDED <span>3</span>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Section 8.1 fiduciary disclaimer replaced with PBM commitment to support Sponsor's ERISA obligations</li> <li><input type="checkbox"/> Section 2.3 preferred-provider clause removed; explicit carve-out rights added without penalty</li> <li><input type="checkbox"/> Pass-through pricing structure replaced with actual-cost pass-through; spread retention eliminated</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Section 9.4 audit restrictions lifted: two audits, Sponsor-selected auditor, extrapolation permitted, aggregator-level access</li> <li><input type="checkbox"/> Rebate definition expanded to cover administrative fees, market development funds, and performance payments</li> <li><input type="checkbox"/> Plan sponsor data ownership and unrestricted access language added</li> <li><input type="checkbox"/> Lowest-net-cost formulary commitment added to clinical standard</li> <li><input type="checkbox"/> Annual sole-revenue certification from PBM</li> <li><input type="checkbox"/> De-identified data monetization restrictions added</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Annual PMPM benchmarking against PBM's book of business for similarly-sized clients</li> <li><input type="checkbox"/> Annual lowest-net-cost analysis documentation requirement</li> <li><input type="checkbox"/> Aggregator audit access confirmed where applicable</li> </ul>

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