Pharmacy Benefit Manager Reforms Address Systemic Issues

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The current pharmacy benefit manager (PBM) system is widely described as fundamentally broken, contributing to rising prescription medicine costs and limited patient access. Recent legislative and regulatory reforms seek to address these systemic issues, with an immediate takeaway for clinicians being a potential shift towards greater transparency in drug pricing and PBM compensation models.

KEY TAKEAWAYS

- The Pivot: New reforms target PBM transparency, rebate practices, and compensation models.
- The Data: Specific data points on cost savings or efficacy are not yet available for these prospective reforms.
- The Action: Clinicians should monitor evolving PBM practices and their impact on formulary design and patient out-of-pocket costs.

Pharmacy benefit managers (PBMs) operate as intermediaries between pharmaceutical manufacturers, health plans, and pharmacies, managing prescription medicine benefits for over 275 million Americans. Their primary functions include negotiating drug prices and rebates with manufacturers, developing and managing formularies, and processing prescription claims. The complexity and opacity of PBM operations have led to concerns regarding their impact on medicine costs, particularly for patients at the point of sale. Critics argue that PBM business models, which often involve retaining a portion of manufacturer rebates or charging spread pricing (the difference between what the PBM charges the health plan and what it reimburses the pharmacy), contribute to inflated drug prices and misaligned incentives. This structure has been implicated in driving up out-of-pocket costs for patients and threatening the viability of independent pharmacies. The lack of transparency in these financial flows makes it challenging for health plans, providers, and patients to understand the true cost of medicines or the value PBMs provide. For patients managing chronic conditions such as diabetes, cardiovascular disease, or autoimmune disorders, where consistent access to specific medications is critical, the financial burden imposed by PBM practices can lead to medication non-adherence. This non-adherence, driven by cost, can result in poorer health outcomes, increased hospitalizations, and a greater overall healthcare expenditure in the long term. The epidemiology of chronic diseases highlights a significant portion of the population reliant on prescription medications, making the efficiency and fairness of the PBM system a public health concern.

Reforms and Their Potential Impact

Recent legislative and regulatory efforts aim to introduce greater transparency and accountability into the PBM system. Key areas of reform focus on several aspects of PBM operations. One significant area is the mandate for increased disclosure of PBM compensation and financial arrangements. This includes requiring PBMs to report the aggregate amount of rebates received from manufacturers and the portion passed on to health plans, as well as detailing any administrative fees or other charges. The intent is to illuminate the financial incentives that may influence formulary decisions and drug pricing. Another reform targets the practice of spread pricing, with proposals to prohibit or limit PBMs from retaining the difference between what they charge health plans and what they pay pharmacies. Instead, some reforms advocate for a pass-through model, where PBMs would be compensated via a flat fee, ensuring that all negotiated discounts and rebates are directly passed to the health plan. This shift aims to reduce the incentive for PBMs to favour higher-priced medicines that yield larger rebates or greater spread. Furthermore, reforms are addressing formulary management, with provisions designed to prevent PBMs from excluding certain medicines from formularies if they offer a lower net cost to the health plan. This is intended to promote access to the most cost-effective treatments for patients. Some proposals also seek to enhance oversight of PBM audit practices, which can impose significant financial burdens on pharmacies. The goal is to ensure that audits are conducted fairly and do not disproportionately impact smaller or independent pharmacies. The implementation of these reforms is expected to be phased, with varying timelines for compliance. The immediate impact on medicine pricing and patient out-of-pocket costs will depend on the specific details of the regulations and the extent to which PBMs adjust their business models in response. While the reforms aim to create a more equitable and transparent system, their effectiveness will require ongoing monitoring and enforcement. A deeper limitation of current PBM models lies in their potential to prioritize short-term cost savings for health plans over long-term patient health outcomes, particularly when formulary decisions restrict access to optimal therapies. The mechanism by which PBMs influence drug selection, often through rebate negotiations, can inadvertently steer patients towards less clinically appropriate or more expensive alternatives if those alternatives offer higher rebates. This can be particularly detrimental for vulnerable patient populations, including the elderly, those with multiple comorbidities, and individuals with rare diseases, who often require specific, sometimes high-cost, medications. The reforms seek to mitigate these limitations by mandating greater transparency and aligning incentives more closely with patient benefit and overall healthcare value.

CLINICAL IMPLICATIONS

The proposed PBM reforms, if effectively implemented, could significantly alter the landscape of prescription medicine access and cost for patients. For clinicians, this may translate into more stable and predictable formulary decisions, potentially reducing the administrative burden associated with prior authorizations and step therapy protocols driven by opaque PBM incentives. A shift towards greater transparency in rebate pass-through and a reduction in spread pricing could mean that the net cost of medicines more closely reflects the price paid by health plans, which might, in turn, alleviate some of the financial strain on patients at the pharmacy counter. This could be particularly impactful for patients managing chronic conditions requiring expensive specialty medicines, where PBM practices have historically contributed to substantial out-of-pocket expenses.

The industry implications are substantial. Major PBMs, such as CVS Caremark, Express Scripts, and

> OptumRx, may need to fundamentally restructure their revenue models. Moving away from spread pricing and rebate retention towards a flat-fee service model would necessitate a re-evaluation of their value proposition to health plans. This could foster greater competition among PBMs based on efficiency and service quality rather than their ability to leverage opaque financial arrangements. Pharmaceutical manufacturers might also face pressure to adjust their list prices if the incentive for PBMs to favour high-rebate medicines diminishes, potentially leading to a more rational pricing environment.
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> Ultimately, the success of these reforms hinges on rigorous oversight and enforcement. The history of PBM regulation shows that these entities are adept at adapting their practices to new rules. Clinicians should remain vigilant, observing whether the promised transparency translates into tangible benefits for patients, such as reduced out-of-pocket costs and improved access to necessary medicines. The true measure of these reforms will be their ability to simplify the complex medicine supply chain and ensure that patient care, rather than profit margins, drives formulary decisions.

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REFERENCES

1. 1. Mattingly TJ 2nd, et al. Pharmacy Benefit Managers: History, Business Practices, Economics, and Policy. JAMA Health Forum. 2023;4(11):e233804. doi:10.1001/jamahealthforum.2023.3804
2. 2. Daniel H, et al. Policy Recommendations for Pharmacy Benefit Managers to Stem the Escalating Costs of Prescription Drugs: A Position Paper From the American College of Physicians. Ann Intern Med. 2019;171(11):823-824. doi:10.7326/M19-0035
3. 3. Drettwan JJ, et al. An Ethical Analysis of Pharmacy Benefit Manager (PBM) Practices. Pharmacy (Basel). 2019;7(2). doi:10.3390/pharmacy7020065
4. 4. Melton TC, et al. Through the lens of rural patients and pharmacies: A content analysis of state level pharmacy benefit manager regulations and policies. Explor Res Clin Soc Pharm. 2025;18:100595. doi:10.1016/j.rcsop.2025.100595

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