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How Brokers Make PBM Recommendations That *Hold Up*



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If someone placed two PBM quotes in front of you side by side with the same discount off AWP, rebate guarantee, and administrative fee, would you be able to tell the difference between the two?

At first glance, there may not be much to separate them. That's exactly the problem. For years, PBM comparisons centered on the numbers that fit neatly into a spreadsheet. But the Rx market has changed faster than the comparison process built around it.

Formulary design, clinical criteria, utilization, drug classifications, and contract terms can all materially change what a plan ultimately pays. Two quotes can look nearly identical on paper and still produce very different outcomes. The challenge isn't broker expertise. It's that the traditional comparison process wasn't built to make all of those variables visible.

What this *paper* will show you

A stronger PBM evaluation starts by understanding what sits behind the price.

In the pages ahead, we'll break down why similar-looking PBM quotes can produce very different results, what's raising the stakes for brokers and their clients, and the three checks that should happen before price is compared.

The goal is simple: a clearer view of the economics behind each offer and a recommendation you can explain with confidence.

Why Unit Price *Stopped Being Enough*

For years, comparing PBMs meant comparing unit price. The main factors brokers would look at were:

- **Discount off average wholesale price**
- **Rebate guarantee**
- **Dispensing fee**

Those numbers are easy to put in a column and explain to a client. So that's what got compared. But unit price can't tell you which claims will show up in the first place. What it shows is what a plan pays per claim.

That second variable, utilization, is shaped by formulary design and clinical criteria: which drugs are preferred, which require prior authorization, and what conditions have to be met before a claim is approved. Two PBMs can offer the same discount and rebate terms and still produce very different total spend because they may be managing very different sets of claims.

Until you understand what drives utilization, you don't have the full price.

Lower Unit Cost *Doesn't Always Mean* Lower Total Cost.

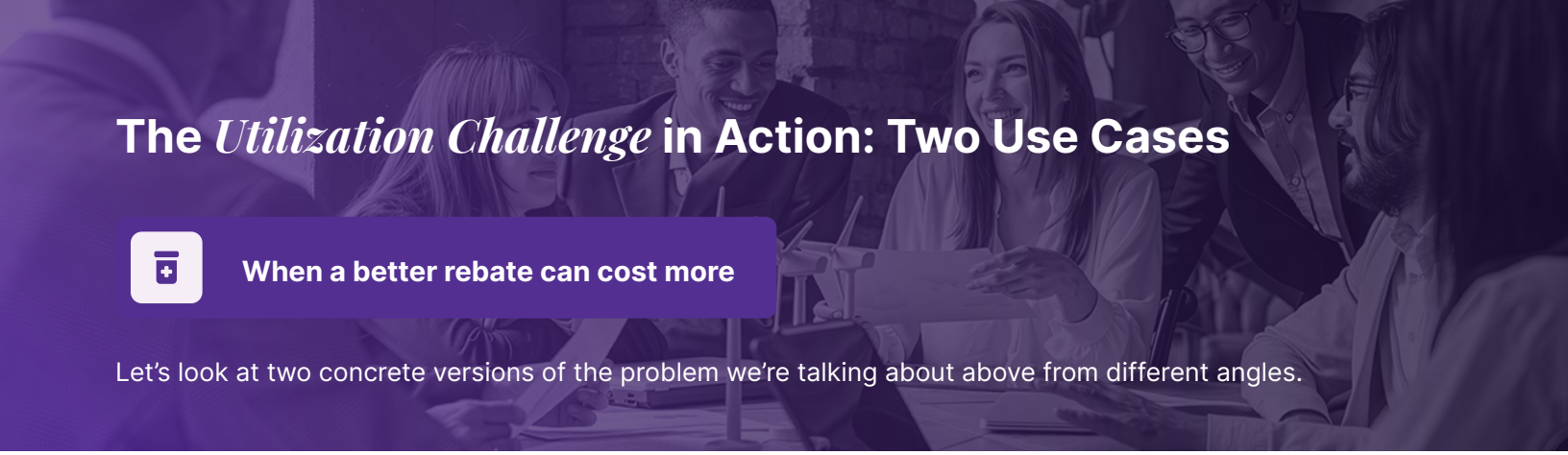
You see this every time you shop in bulk. Buy more and the price per unit usually comes down. That can be a good deal, but only if the amount you're buying makes sense. A lower unit price on more volume can still leave you with a bigger total bill.

PBM pricing can work the same way. One PBM can show a better discount while its formulary and clinical criteria drive more utilization. Another can show a less aggressive discount but produce lower total spend.

That's why unit price only tells you part of the story.

For years, the market got very good at answering, "What's my discount?" The harder question is, "What will actually be dispensed, and why?"

Formulary strategy and clinical criteria help answer those questions.



The *Utilization Challenge* in Action: Two Use Cases

When a better rebate can cost more

Let's look at two concrete versions of the problem we're talking about above from different angles.

1 Skyrizi vs the $3,000 Drug

A patient with plaque psoriasis can be treated with Skyrizi, at an annual list price of approximately $95,000 a year, or with a biosimilar version of Humira, called Yusimry, at less than $13,000 a year.[1] Skyrizi may well be the better clinical option for that patient. That's a real, defensible reason to prefer it.

But a unit-price comparison alone misses an important part of the picture. The manufacturer of a higher-cost drug has every incentive to offer a PBM better net pricing in exchange for volume. If there's no clinical protocol steering utilization, that plan is going to fill more of the expensive option, and the PBM is going to look like it negotiated a great deal, because on paper it did. The rebate guarantee can be excellent, and the total spend can still be far higher than a plan with tighter formulary controls and a smaller headline discount.

Neither PBM in this scenario did anything wrong here. The manufacturer wants volume. The PBM wants competitive pricing and rebate terms. Both incentives are rational. What the buyer needs to see is which drugs the plan is being steered toward before comparing what each PBM charges for them.

2 GLP-1s and Patient Qualification

With GLP-1 medications like Ozempic and Trulicity, the swing isn't about which drug gets used but rather how many patients qualify.

If a plan's clinical criteria simply require a diabetes diagnosis, nearly every diabetic patient becomes eligible. If the criteria require documentation that the patient is an unmanaged diabetic, roughly half of the diabetic population no longer qualifies, because a meaningful share of diabetics is already well managed. That single criterion can cut utilization, and spend, by half.

A manufacturer selling into a large, loosely managed population is going to offer a better price than one selling into a smaller, tightly managed one, for the same reason a wholesaler discounts a bigger order.

The price a plan sees depends entirely on the utilization-management decisions made before pricing enters the conversation. Compare two quotes without knowing what clinical criteria sit behind them and you're comparing two different populations that happen to have numbers attached instead of comparing prices.

1 Source: AbbVie. (2026). SKYRIZI cost and savings. Retrieved July 30, 2026, from https://www.skyrizi.com/psoriasis-psoriatic-arthritis/cost-and-savings; Coherus BioSciences, Inc. (2023, July 3). Coherus launches YUSIMRY, a biosimilar of Humira, at $995 per carton in U.S. https://www.globenewswire.com/news-release/2023/07/03/2698528/0/en/coherus-launches-yusimry-a-biosimilar-of-humira-at-995-per-carton-in-u-s.html; U.S. Food and Drug Administration. (2025, November). YUSIMRY (adalimumab-aqvh) prescribing information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761216s007lbl.pdf

The Market *Optimized* For What Buyers Measured

For years, PBM evaluations centered on discounts, rebates, and other unit-cost measures. Those numbers fit neatly into a spreadsheet, so that is where competition naturally concentrates. Formulary strategy and clinical criteria received less attention because they are harder to see and harder to compare. This wasn't some malicious act by the PMs. Every market responds to what buyers value and measure.

The result is a market that became very good at answering one question:

What's the price?

Today, brokers increasingly need to answer another: What is driving the utilization behind that price? That matters more now because pharmacy spend is larger, clients are asking harder questions, and the process

Why This *Matters More* Now

Twenty years ago, prescription drugs made up just more than 10% of the total U.S. healthcare spending. Many employers shopped the medical plan and let the PBM that came with it handle pharmacy side because the dollars involved drew less scrutiny.

That number has greatly inflated. Rx spend now averages north of 25%[2] and in some cases could rise to nearly 50% of overall spend, particularly for plans with significant specialty-drug utilization. That shift isn't primarily about list prices climbing. There are a mix of factors, including more specialty drugs being prescribed and a fast-growing share of members on GLP-1s and other high-cost categories.

The same claim volume now carries a much bigger price tag, and it's landing on a part of the plan that historically got the least attention. When a line item is 5% of spend, an imprecise comparison is an inefficiency. *When it's approaching half of spend, the same imprecision is a material financial decision, and it starts getting treated like one.*



2 Source: Dietz, E. (2004, August). Trends in employer-provided prescription-drug coverage. Monthly Labor Review, 127(8), 37–45. https://www.bls.gov/opub/mlr/2004/08/art5full.pdf; Business Group on Health. (2025, February 21). Taking action on pharmacy benefits: A Business Group on Health viewpoint. https://www.businessgrouphealth.org/resources/pov-taking-action-on-pharmacy-benefits

Non-Optional *Transparency*

As pharmacy took on a bigger slice of the pie, its workings became more scrutinized.

Since December 2021, Section 202 of the Consolidated Appropriations Act has required brokers and consultants working with ERISA group health plans to disclose their direct and indirect compensation. Employers are entitled to a clear, written accounting of how their broker gets paid, from every source, before a contract is signed, extended, or renewed.

That requirement has been on the books for a few years now, but a newer round of legislation is building directly on top of it, adding more detailed reporting expectations and new audit rights. Whatever form the final rules take, the direction is consistent. Brokers and consultants are facing greater expectations for documented, defensible behind-the-scenes processes behind their recommendations.

That changes what you need to produce a valuable PBM comparison. It's no longer enough to arrive at a good number. The plan sponsor increasingly needs to be able to show how that number was reached, and what sits behind it.

Non-Theoretical *Fiduciary Risks*

The greater scrutiny around pharmacy benefits is also showing up in the courts. Beginning in 2024, plan participants filed ERISA breach-of-fiduciary-duty lawsuits against JPMorgan Chase, Wells Fargo, and Johnson & Johnson, challenging how each company selected or monitored PBM pricing and formulary decisions on behalf of its health plan and members.

The legal questions are still unsettled, but it brings up an important conversation. The core fiduciary-duty claims in the Johnson & Johnson case were dismissed for lack of standing, as was the amended complaint against Wells Fargo, and those rulings are on appeal. In the JPMorgan case, two fiduciary-duty counts were dismissed while two prohibited-transaction counts were allowed to proceed.[3]

These are not a string of employer losses. But they do show that PBM oversight is receiving a level of attention that did not exist a few years ago. And they raise a broader question for plan sponsors and the advisors who support them: Can you show how the PBM recommendation was reached?

"We trusted the numbers" is not the answer people want to hear today.



3 Source: Lewandowski v. Johnson & Johnson, No. 3:24-cv-00671 (D.N.J. Nov. 26, 2025), appeal docketed, No. 26-1107 (3d Cir. Jan. 16, 2026); Navarro v. Wells Fargo & Co., No. 0:24-cv-03043 (D. Minn. Mar. 3, 2026), appeal docketed, No. 26-1620 (8th Cir. Apr. 1, 2026); Stern v. JPMorgan Chase & Co., No. 1:25-cv-02097 (S.D.N.Y. Mar. 9, 2026).

The *Convergence* of Pressures

None of the shifts mentioned above (spend, disclosure, and fiduciary exposure) is new information on its own. What's different is that they are converging on the same decision at the same time. You have a pharmacy spend that is large enough to command C-suite attention. Then add in that transparency expectations are increasing and greater scrutiny is being placed on how PBMs are selected and monitored.

All of this alters the standard for the broker recommendation. A comparison based on discount and rebate guarantees alone may miss meaningful differences in total cost. And if a client's finance team, board, regulator, or other stakeholder asks why one PBM was recommended over another, the broker needs more than the final spreadsheet to answer. The evaluation has to make the economics clear and show how the recommendation was reached.

Together, these pressures are raising the standard for PBM evaluations. Brokers now need a comparison process that is not only accurate, but also documented and defensible.



Three Checks Behind a *Stronger* PBM Evaluation

A more defensible PBM recommendation starts with three checks. The important part is doing them before comparing price. These three areas must be accomplished in this order or else your comparison won't hold up.

1 Start With Data You Didn't Get from the PBM

PBM comparisons depend on knowing the average wholesale price of the drugs in the claims file because AWP is the baseline against which many discounts are measured. The challenge is that brokers do not always have independent access to that information. The common workaround is to ask the PBM to provide it, which means relying on the party being evaluated to supply the baseline used to measure its own performance.

That causes a clear conflict of interest built into how the comparison gets done. And there is a cleaner way to do it. Pull AWP and drug-classification data from an independent third-party source. It's the same principle as using an independent appraisal in a real-estate transaction instead of relying on the seller to establish the value.

Once the baseline comes from outside the deal, the pricing built on top of it becomes more meaningful.

2 Translate Every Bid Into a Common Language

While independent data gives you a neutral starting point, the catch is that PBMs don't all classify drugs the same way. Which is why next you need a common set of definitions.

PBMs may use the same labels (brand, generic, specialty, and limited distribution) differently, and those differences can determine which pricing tier, guarantee, exclusion, or contract term applies. A drug can land in a different category from one PBM to the next even when the percentages on the page look nearly identical.

Before you compare the economics, translate each bid onto the same terms. Confirm what the definitions mean, which drugs fall underneath them, and where those differences could change the economics.

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3 Normalize Utilization Before Price Enters the Conversation

Once the bids are using the same definitions, the next step is making sure they're modeling utilization on the same basis. Formulary strategy and clinical criteria can materially change what gets used and how much utilization a plan ultimately sees. Start by asking whether the PBMs align on:

- **Preferred drug for a given condition?**
- **Prior authorization requirements?**
- **Clinical thresholds, like whether a GLP-1 requires a documented diagnosis of uncontrolled diabetes or just diabetes generally?**

Once those variables are aligned, or normalized onto a common set of assumptions, price becomes a meaningful comparison. A richer rebate or deeper discount may simply be sitting on top of a different drug mix or a more favorable utilization scenario.

Making That Standard *Repeatable*

Each of these checks is doable on its own. Applying all three consistently across thousands of drugs, multiple formularies, and competing contracts, case after case, is harder. That's what LinQ makes repeatable. It brings independent data, common definitions, clinical criteria, and utilization assumptions into one evaluation and applies them consistently across every bidder before the financial comparison is built.

The result is a clearer view of which PBM is producing the better economic result rather than the previous process of simply which one was given the most favorable assumptions.

The brokers who can bring that level of analysis to every case are giving their clients a better answer to the question that matters most: How do we know this is the right recommendation?

Put the methodology to work on your next case.

Get a pre-market analysis