



An Industry in Flux: How to Navigate the Complex Pharmacy Benefits Landscape with Confidence

*Legislation, Transparency, and
the Future of Pharmacy Benefits*





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Quick-Reference Summary:

Key Takeaways



Legislative Changes

- **Federal reforms like the Consolidated Appropriations Act of 2026 demand 100% rebate pass-through** and stricter fiduciary responsibilities for employers.
- **State-level regulations are increasing compliance burdens**, with ERISA preemption no longer guaranteed for self-funded plans.
- Employers must maintain **transparent, well-documented benefit arrangements** to meet dual compliance requirements.

PBM Pricing Models

- **Three core pricing models dominate the pharmacy benefits landscape:** Traditional Spread-Based, Transparent Rates and Pass-Through Rebates, and Modular Transparent Models (that include Cost-Plus options and other cost containment programs).
- **Individual group underwriting is becoming critical**, with drug mix and utilization driving financial outcomes.
- Transparent pricing models offer clarity but **require careful evaluation of guarantees and rebate structures.**

Clinical Utilization Management

- **Specialty drugs account for over 55% of pharmacy spending**, driven by just 2% of members.
- **The most expensive medication a plan pays for is the one that wasn't necessary.**
- **Independent clinical management ensures every dollar spent aligns with both clinical necessity and financial prudence.**

Actionable Steps for Benefits Advisors

- **Audit PBM contracts** to identify hidden fees and ensure compliance with new regulations.
- **Benchmark PBM performance** against industry standards and alternative cost-containment solutions.
- **Educate clients** on the financial and operational impacts of transitioning to transparent pricing models.
- **Partner with independent clinical oversight organizations** to validate prescription necessity and optimize plan design.

Why It Matters

Advisors who adapt to these changes and provide clear, actionable guidance will solidify their value in the evolving PBM landscape.

The pharmacy benefits management (PBM) industry sits at a critical crossroads.

Rapid legislative reform, new transparency demands, and evolving pricing models are fundamentally transforming pharmacy benefits management for self-funded employers. For benefits advisors, this presents both challenges and new opportunities to lead.

Understanding Legislative Changes: Federal, State, and ERISA Implications



The regulatory environment for pharmacy benefits is changing significantly at both federal and state levels. For benefits advisors, it is imperative to distinguish between the requirements that new federal laws impose, the obligations that emerging state regulations introduce, and the changing role of ERISA protections for plan sponsors.

Federal Mandates: New Standards for PBMs and Employers

Federal reforms—most notably the **Consolidated Appropriations Act of 2026**—impose direct, enforceable mandates directly on PBMs. Key mandates include **100% rebate pass-through**, strict limitations on PBM income via fixed administrative/service fees, and comprehensive disclosure of total pharmacy spend.

For employers serving as plan sponsors, federal law now imposes a heightened fiduciary responsibility to act prudently and in the best interest of plan participants. Enforcement shifts mean employers must maintain a level of ongoing oversight and documentation to demonstrate that benefit arrangements—across the drug portfolio—are structured to meet aggregate, lowest-net-cost standards.

The Department of Labor has intensified oversight by proposing comprehensive fee disclosure rules, placing greater accountability on both PBMs (as service providers) and the employers who select them. These requirements mandate that both PBMs and employers maintain transparent, well-documented benefit arrangements.



“ERISA preemption is no longer a guaranteed shield. Employers must now prepare for dual compliance at both federal and state levels, and advisors play a critical role in ensuring they’re ready.”

Wes Hill | *Vice President, Regulatory Affairs, Managing Counsel, RxBenefits*

States Legislation: Growing Compliance Burden and Limited ERISA Shield

Concurrently, many states are rapidly enacting their own pharmacy benefit laws to increase transparency and control costs.

These statutes introduce mandates such as National Average Drug Acquisition Cost (NADAC)-based reimbursements, minimum dispensing fees (intended to level the playing field for private pharmacies and thereby increase market competition), and explicit transparency and rebate pass-through requirements directed at PBMs.

Landmark actions, such as **California's law imposing a fiduciary duty on PBMs**, further elevate PBM compliance standards by legally requiring them to act in the best financial interests of their clients. A major industry group, the Pharmaceutical Care Management Association (PCMA), is currently fighting the California law. The outcome of the case will set a precedent. If California wins, other states will likely pass similar laws. If PCMA wins, it will likely limit how much states can regulate PBMs that serve self-funded plans.

While ERISA (the Employee Retirement Income Security Act of 1974) has long shielded self-funded employer plans from most state insurance mandates, recent litigation has narrowed this protection. Ongoing legal challenges in states like Iowa, Arkansas, and Tennessee have tested the boundaries of ERISA preemption and introduced significant uncertainty regarding whether and to what extent self-funded plans must also comply with new state laws—especially those imposing fiduciary standards. While these state laws aim to protect local pharmacies and create fairness, plan sponsors may see rising pharmacy costs and more administrative headaches if they are enacted, especially employers operating in multiple states.

What the Courts are Saying

Legal precedent indicates that **plan sponsors who can demonstrate their benefit designs achieve the lowest aggregate cost for their population—based on comprehensive, data-driven oversight—are best positioned to comply with modern fiduciary standards.** Rather than focusing solely on line-item drug pricing, forward-thinking sponsors can successfully defend their fiduciary management by demonstrating a disciplined approach: negotiating and managing the benefit across the entire drug mix, with the objective of optimizing total plan value and compliance.

Practical Guidance for Navigating Unfolding Legislation

Federal law sets the minimum standard; state laws often add layers, and ERISA preemption is no longer a guaranteed shield for self-funded employers. PBMs are now responsible for dual compliance at both levels. Employers must both act prudently and maintain thorough documentation. Understanding and navigating the intersection of these obligations through careful review of pharmacy contracts is now a core competency for anyone advising clients in the pharmacy benefits space.

Actionable Takeaways

- 1 Choose a pharmacy partner who deeply understands and commits to comply** with evolving federal and state regulations.
- 2 Stay vigilant**—review PBM contracts carefully to ensure they address federal and state-specific rules.
- 3 Most importantly, educate your clients** about the potential for increased costs so they can make informed decisions and adapt their benefits strategies as the regulatory environment continues to evolve.

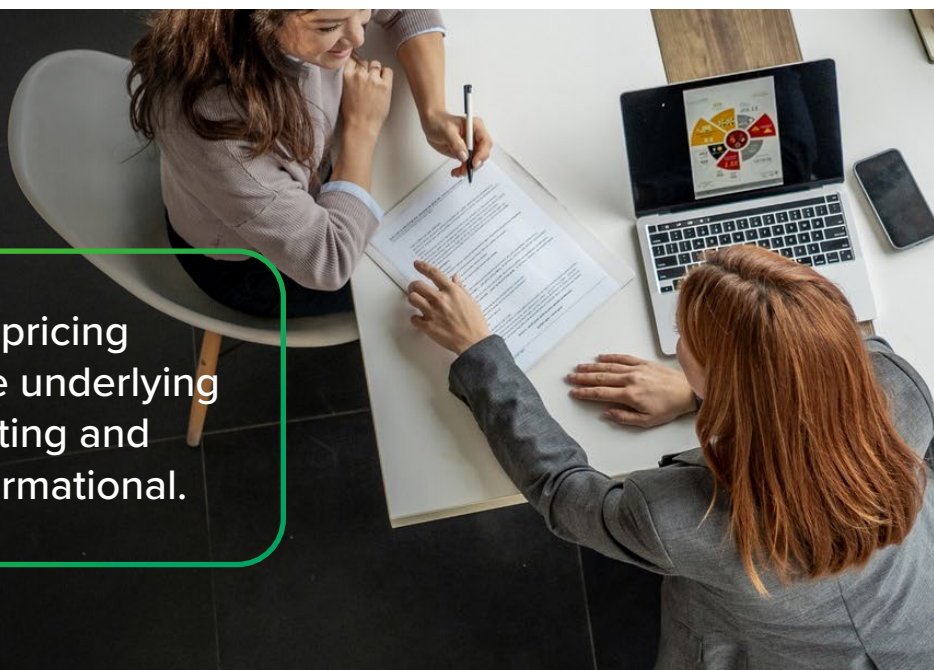
PBM Pricing Models: The Three Core Structures



Benefits advisors will best understand the modern PBM market through the lens of three primary pricing models—each with unique underwriting mechanics, structural attributes, and strategic implications for delivering sustainable, compliant cost control to clients.

The Underwriting Evolution: Block vs. Individual

Before we dive into the three pricing models, let's examine how the underlying mechanisms behind underwriting and rebate distribution are transformational.



The chosen underwriting structure for each model impacts plan sponsors very differently based on their underlying utilization—or drug mix. Understanding how the two primary underwriting models now in use interact with rebate structures is critical to steer each of your clients to the best go-forward option.

Block Underwriting:

- This approach pools multiple employer groups together to smooth out risk and reduce financial volatility.
- The PBM bases administrative fees and rebate guarantees on the aggregate performance of the entire pool, rather than the specific claims of an individual employer.
- This model is the one you're familiar with via the Big 3. It's relatively easy to explain.
- This underwriting approach yields favorable results for groups with low specialty utilization, average or lower GLP-1 utilization, brand and specialty medications that do not drive substantial rebate value, and/or a high volume of HIV claims, as they benefit from the higher rebate payouts earned by other employers in the block.

Individual Group Underwriting:

- Group-level underwriting aligns rebate value to client specific drug mix and utilization.
- If rebates available for a client’s actual drug mix are lower than the historic average guaranteed value, then clients will be disadvantaged, meaning they will see a reduction in rebate value.
- High-rebate groups (those with heavy non-HIV specialty utilization and/or a lot of GLP-1 utilization) are advantaged by this model. They benefit the most as they earn the full rebate value for their actual claims.

The bottom-line is going forward—individual client drug mix matters.



“The shift to individual group underwriting is a double-edged sword. While it offers tailored solutions, it also demands a deeper understanding of each client’s drug mix and utilization patterns. Advisors who master this will deliver unmatched value.”

Nathan White | *Chief Client Officer, RxBenefits*

The Three Principal Pricing Models and Their Underwriting Mechanics

You can best understand the landscape of pharmacy benefits management not by categories of PBM entities, but by the structure of their pricing models—each underpinned by distinct underwriting mechanics that shape financial outcomes for employer plans. As major PBMs and new market entrants alike embrace a spectrum of innovative pricing structures, it is essential for advisors to evaluate both the model and the corresponding risk-sharing or underwriting approach in the context of their clients’ plan utilization data to ensure alignment with plan sponsor objectives.

1

**Traditional
Spread-Based/Rebate
Dependent Model**

2

**Transparent
Rates and Pass-Through
Rebates**

3

**Modular Transparent
Models with Cost-Plus
Network Options**

1 Traditional Spread-Based/Rebate Dependent Model

Definition: The PBM profits by charging the employer more than what is paid to pharmacies (spread pricing) and retaining a portion of manufacturer rebates.

Who uses it: The major PBMs (CVS Caremark, ESI/Evernorth, OptumRx) have operated in this way for decades.

Underwriting: Risk is pooled across employer groups. Guarantees apply at the block level rather than the individual group.

Implications: True drug costs are obscured, and incentives may not align with employers' best interests.

2 Transparent Rates and Pass-Through Rebates

Definition: All discounts and rebates are passed directly to the plan sponsor; PBM revenue comes from fixed administrative fees.

Who uses it: Both established PBMs (with offerings like CVS TrueCost, OptumRx Clear Trend Guarantee, and ESI's pass-through model) and disruptors such as SmithRx and Rightway.

Underwriting: Relies on individual group-level risk assessment, with plan-specific drug mix and utilization dictating outcomes.

- Plans with ample utilization of highly rebateable specialty drugs or significant GLP-1 utilization typically benefit most. These plans are advantaged by a move to drug-level rebates.
- Plans with low specialty utilization overall or high utilization of specialty drugs that yield low rebates (e.g. HIV medications) may lose value without pooled guarantees.

Variation in Guarantees: Large PBMs may provide group-level guarantees; smaller PBMs may cap their risk with per-member-per-month (PMPM) limits, which do not always guarantee outcomes-based results.



3

Modular Transparent Models with Cost-Plus Network Options

Definition: Plan sponsors are allowed to direct members, via flexible networks and formularies, to the lowest-cost source for each drug. Some prescriptions may be filled through third parties (e.g. Costco, Mark Cuban Cost Plus, Amazon Pharmacy) based on actual drug acquisition cost plus a fixed markup.

Who is here now: Illuminate Rx, an RxBenefits affiliate.

Who is moving here: CVS CostVantage and aspects of OptumRx's programs exemplify this shift.

Key Considerations:

While point-of-sale price may be lower at cost-plus pharmacies, this may not reflect the net plan cost when rebates are considered.

Additional network flexibility may not offer consistent economic benefit —administrative burden can increase without clear financial upside.

These options are best used as one component of a broader, more modular pharmacy benefits strategy tailored to specific high-impact medications.

Emerging Trend in Embracing Direct-to-Consumer Platforms

In addition to cost-plus providers, we are seeing an emerging trend as some PBMs attempt to design options to leverage direct-to-consumer platforms within the benefit. The goal is to shift some portion of plan costs to employees with the added benefit of lowering the employee's out-of-pocket costs for expensive therapies like GLP-1s for weight loss.

Definition: Direct consumer cash payments for medications at negotiated prices, outside the insurance and PBM system.

Who uses it: Emerging platforms like TrumpRx, with similar strategies enabled by LillyDirect® and other companies.

Implications: While members may see savings on select drugs, employers may lose data integration, oversight, and clinical management capabilities until these models mature.

Transparent and “Disruptor” PBMs: Advantages and Limitations

Many clients stand to benefit from transparent pricing and pass-through, drug level rebate payouts, but choosing the right transparent PBM partner is not without its challenges.

Advantages

- Clear pricing and rebate flows.
- Administrative fees are defined up front.
- Employers have greater visibility and therefore better support complying with fiduciary responsibilities.

Limitations

- Many newer transparent PBMs cannot provide direct guarantees and rely on PMPM caps without outcome assurances.
- Limited operational scale constrains their ability to deliver consistent results. Scalability concerns begin with quality implementation but extend well beyond.
- Many new market entrants lack the robust account management infrastructure needed to support a growing client base, making it challenging to maintain high-touch service levels and proactive plan guidance as they scale. This limitation can result in delayed issue resolution, reactive rather than strategic support, and gaps in reporting and analytics capabilities.
- Benefits advisors and employers find that despite transparent pricing, PMPM trend is not well managed over time. Advanced data support and proactive clinical rigor accompanied by high-touch member support are needed to guide members with high-cost prescriptions to lower-cost medications.

New Entrants to Consider:

Illuminate Rx, along with emerging models from the Big 3, now offers transparent or modular solutions that extend beyond classic binary transparent PBM category definitions.



“The PBM landscape is more complex than ever, but it’s also full of opportunity. Advisors who ask tough questions and demand flexibility with a clinically led cost-management approach don’t just protect their clients—they build lasting trust.”

Ritu Malhotra, PharmD | *Clinical Pharmacist, Experienced Benefits Consultant, President, Illuminate Rx*

How the Big 3 PBMs Are Adapting

Faced with legislative requirements and client demands for transparency, CVS Caremark, OptumRx, and ESI/Evernorth are expanding their offerings to include these new models:



CVS Caremark:

- **TrueCost:** Transparent, drug-level rebates—shifts away from classic spread.
- **CostVantage:** Utilizes a cost-plus formula, aligning more closely with transparent practices.



OptumRx:

- **Clear Trend Guarantee:** Tethers reimbursement directly to third-party benchmarks.
- **Costs Made Clear:** Flexible suite with options for 100% pass-through and cost-plus.



ESI/Evernorth

- **Eliminating spread pricing by 2027,** moving to out-of-pocket costs based on net drug prices in response to regulatory action.

Actionable Takeaways

Practical Guidance for Evaluating a Landscape of Options

The right underwriting and rebate approach can make or break a plan sponsor's financial strategy. By matching the underwriting model directly to your client's specific risk profile and population data, you can maximize their rebate yield and protect their budget from unpredictable industry shifts.

1

Analyze Plan-Level Utilization Data:

Before recommending an underwriting model, thoroughly evaluate your client's current specialty drug utilization, HIV and GLP-1 volume, and overall drug mix.

2

Look Beyond the Baseline Guarantee:

Ensure you and your client fully understand whether the PBM offers a pooled rebate guarantee or passes through the specific group's actual earned rebates.

3

Focus on Lowest Net Cost:

Guide smaller, rebate dependent clients toward the predictable stability of block underwriting while it is still available and prepare them for a future where this model disappears. For clients with high specialty and GLP-1 utilization, recommend the customized, high-yield potential of individual underwriting.

Clinical Utilization Management: The Real Key to Cost Control



Aligning clients to the best fit pricing model is a step in the right direction, but it won't solve the cost crisis on its own. The real unlock lies in robust clinical utilization management (UM) strategies that tackle the root causes of wasteful spending—like the overuse of specialty drugs and high-cost GLP-1s.

Not all utilization management programs apply the same level of clinical rigor or achieve the same results.

When PBM revenue streams tie back to drug volume, formulary placement, or specific rebate guarantees, the system inadvertently favors higher-cost medications, even when equally effective, lower-cost alternatives exist.

This structural misalignment can lead to prescription approvals that deviate from strict U.S. Food and Drug Administration (FDA) guidelines, established clinical best practices, or the explicit design of a pharmacy benefits plan. A clear example of this is the approval of high-cost medications for off-label indications—such as authorizing GLP-1 therapies for weight loss when a plan explicitly excludes weight loss treatments from its coverage. When the entity managing approvals benefits financially from the transaction, the threshold for clinical appropriateness often weakens.

To achieve meaningful cost control, clinical management must operate independently of drug dispensing and rebate revenues. When independent clinical pharmacists evaluate claims, they bring unbiased judgment to the review process. Because their financial incentives align directly with the health plan rather than the volume or cost of the drugs dispensed, they make determinations based strictly on medical evidence, safety guidelines, and the specific rules of the plan.

This independent oversight ensures that every approved medication is clinically necessary and appropriate for the patient. By separating clinical decisions from dispensing and rebate incentives, health plans can effectively eliminate wasteful spending while supporting better health outcomes.

Why Independent Clinical Management Matters Now

Nothing drives up pharmacy spend more than authorizing medications that are not medically necessary—the most expensive drug any plan can pay for is the one that never should have been approved.

- **Specialty Drug Growth:** Specialty drugs account for over 55% of drug spending, driven by just 2% of members.
- **GLP-1 Utilization Surge:** Up to 40% of GLP-1 prescriptions are for weight loss, creating unintended costs for plans.
- **Direct-to-Consumer Advertising:** \$7 billion in ad spending influences patients to request costly brand drugs, with prescribers fulfilling 70% of these requests—even when more cost-effective options exist.
- **Provider Detailing:** Pharma marketing to prescribers promotes high-cost drugs over equally effective, lower-cost generics, impacting prescribing patterns.
- **Off-Label Prescribing:** Providers prescribe drugs for conditions the FDA has not approved, often because the FDA has found them lacking evidence.



“Specialty drugs account for over half of pharmacy spending, yet only a small percentage of members drive these costs. Independent clinical oversight is the key to ensuring every dollar spent aligns with both clinical necessity and financial prudence.”

Dr. Mark Campbell | *Clinical Pharmacist and Utilization Expert, Chief Clinical Officer, RxBenefits*

Clinical Strategies to Drive Sustainable Savings

To help employers achieve the lowest net cost, clinical management must be the foundation of your strategy:

- **Data-Driven Plan Design:** Analyze claims data to identify wasteful spending and implement targeted UM solutions.
- **Formulary Optimization:** Prioritize cost-effective medications like generics, biosimilars, and clinically appropriate alternatives.
- **Independent Prior Authorization Reviews:** Use unbiased clinical reviews to ensure appropriate medication use and explore cost-saving alternatives.
- **Therapeutic Interchange:** Collaborate with prescribers and pharmacists to safely substitute high-cost drugs with effective, lower-cost options.
- **Parity Pricing:** Optimize costs by addressing inefficiencies, like prescribing one higher-dose tablet instead of multiple lower-dose ones.

While pricing models are important, they are only part of the equation. Independent (unbiased) clinical utilization management isn't just a tool – it's the cornerstone of navigating the complexities of today's PBM landscape to create a sustainable and well-managed plan.

Actionable Takeaways for Benefits Advisors



These trends highlight the critical role benefits advisors play in advocating for their clients and navigating the evolving PBM landscape. By asking the right questions, auditing contracts, and benchmarking performance, you can position yourself as an indispensable partner in delivering sustainable cost control and compliance.

Questions to Ask PBMs and Initial Steps to Evaluate Their Offerings

To ensure your clients achieve sustainable cost control and compliance, here's a list of key questions to ask PBMs:

Transparency and pricing models:

- Does the PBM offer 100% rebate pass-through, and how are administrative fees structured?
- What benchmarks (e.g. NADAC) does the PBM use to determine drug pricing?
- How does the PBM handle spread pricing, and are there any hidden fees?

Regulatory compliance:

- How does the PBM ensure compliance with state and federal transparency mandates?
- What measures are in place to address fiduciary responsibilities and avoid legal risks?

Data access and reporting:

- What level of detail does the PBM provide in drug utilization, pricing, and rebate reports?
- Can employers access real-time data to monitor plan performance and costs?

Clinical oversight and utilization management:

- Does the PBM include proactive clinical reviews and independent oversight in the service offering?

Flexibility and customization:

- How does the PBM accommodate unique employer needs, such as unbundled models or direct-to-employer pathways?
- What options are available for integrating innovative solutions like cost-plus pricing or direct-to-consumer discounts?

Initial steps to evaluate PBM offerings

1

Conduct a contract audit:

Review existing PBM contracts to identify hidden fees, misaligned incentives, and areas of non-compliance with new regulations.

2

Benchmark against industry standards:

Compare the PBM's pricing models, transparency practices, and clinical strategies against industry benchmarks and alternative cost containment solutions.

3

Engage in scenario planning:

Assess the financial and operational impact of transitioning to drug-level rebates or a transparent PBM model, considering factors like specialty drug utilization and plan design.

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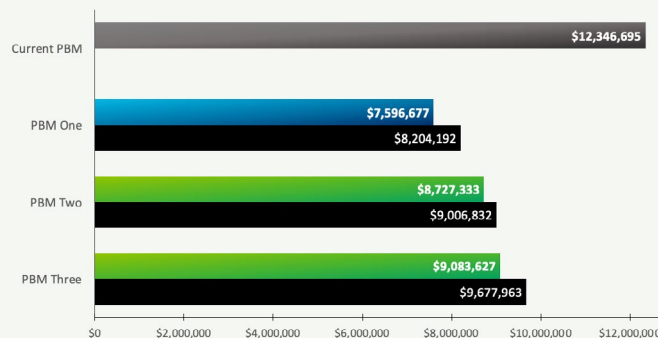
Leverage independent expertise:

Partner with independent consultants or clinical oversight organizations to validate PBM claims and ensure alignment with employer goals.

5

Monitor market trends:

Stay informed about emerging PBM models, regulatory changes, and competitive dynamics to anticipate future challenges and opportunities.





Conclusion: Lead the Way in a Transforming PBM Landscape

In the rapidly evolving pharmacy benefits landscape, standing still is not an option. Employers demand more than transparency—they need strategies that deliver the lowest net cost, mitigate legal risks, and improve member health and satisfaction. Benefits advisors who adapt and lead with expertise will thrive; those who don't risk being left behind.

The PBM landscape of 2026 is shaped by legislative mandates, strategic shifts from major players, and an explosion of pricing models. For employers, this complexity is daunting. As a trusted advisor, **you can rise above the noise by delivering clear, actionable guidance and prioritizing proof over promises.** By asking the tough questions, auditing contracts, and benchmarking PBM performance against new standards, you ensure your clients are never disadvantaged by shifting market trends.

True cost control goes beyond pricing models—it demands rigorous data analysis, targeted strategies, and independent clinical utilization management to eliminate wasteful spending while ensuring members receive the right drug at the right time. A proactive clinical strategy drives sustainable savings, improves plan finances, and enhances member well-being.

By focusing on transparency, clinical oversight, and measurable results, you build trust and solidify your value. Guiding employers to PBM partners who prioritize clarity and waste reduction ensures compliance, mitigates risk, and delivers lasting cost containment.

Differentiate yourself, protect your reputation, and grow your business by leading with expertise in this transforming industry. The time to act is now.



“Benefits advisors are no longer just intermediaries—they’re strategic partners. Advisors who can interpret complex data, audit contracts, and benchmark performance will set themselves apart in this evolving landscape.”

Jesse Schultz | *Senior Vice President, Broker Relations, RxBenefits*

Stay tuned for future installments in this series, designed to help you navigate the evolving PBM landscape and deliver meaningful value to your clients.

Glossary of Terms

- **Cost-Plus Pricing:** A pricing model where the cost of a drug is based on its wholesale acquisition cost plus a fixed markup, often used in transparent PBM models.
- **Drug Level Rebates (DLR):** A pricing model where rebates are calculated and passed through based on the specific drugs utilized by a plan, rather than pooled across multiple groups. This approach ensures transparency and aligns rebate value with actual drug usage.
- **ERISA (Employee Retirement Income Security Act of 1974):** A federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to protect individuals in these plans.
- **Fiduciary Responsibility:** The legal obligation of plan sponsors to act in the best financial interest of plan participants, ensuring benefits are managed prudently and transparently.
- **GLP-1 Utilization:** Refers to the use of glucagon-like peptide-1 receptor agonists, a class of medications often prescribed for diabetes and weight management. High utilization can significantly impact plan costs.
- **NADAC (National Average Drug Acquisition Cost):** A benchmark used to determine the average cost pharmacies pay to acquire medications. It is often used in state-level reimbursement mandates.
- **Pass-Through Pricing:** A transparent pricing model where the PBM passes all discounts and rebates directly to the plan sponsor, charging only a fixed administrative fee.
- **PBM (Pharmacy Benefits Manager):** An intermediary that manages prescription drug benefits on behalf of health plans, employers, and other payers. PBMs negotiate pricing, manage formularies, and process claims.
- **Specialty Drugs:** High-cost medications used to treat complex or rare conditions, such as cancer or autoimmune diseases. These drugs often require special handling and administration.
- **Spread Pricing:** A PBM pricing model where the PBM charges the plan sponsor more for a drug than it reimburses the pharmacy, keeping the difference as profit.
- **Wholesale Acquisition Cost (WAC):** The manufacturer's list price for a drug when sold to wholesalers or direct purchasers, not including discounts or rebates. WAC is often used as a benchmark for drug pricing but does not reflect the actual net cost paid by pharmacies or health plans.

This report is authored by RxBenefits.

About RxBenefits

Birmingham, AL-based [RxBenefits, Inc.](#) is the industry's first and only pharmacy benefits optimizer (PBO), dedicated to helping clients contain rising pharmacy costs while ensuring employees have access to affordable, high-quality prescription medications. RxBenefits provides businesses with expert advocacy, flexible pharmacy benefits solutions, and actionable, data-driven insights that deliver meaningful savings without compromising member care or satisfaction. Through a client-aligned, transparent approach, RxBenefits helps businesses achieve sustainable financial success while maintaining a member-centric focus.

RxBenefits offers clients a curated marketplace of pharmacy benefits management and specialty cost containment solutions backed by a team of more than 1,000 multidisciplinary experts that empowers organizations to design plans that prioritize transparency, long-term stability, and member well-being. With a commitment to driving strategic savings and fostering sustainable results, RxBenefits is revolutionizing pharmacy benefits for self-funded employers of all sizes.

Its affiliate PBM, [Illuminate Rx, Inc.](#), is redefining pharmacy benefits management with unprecedented clarity and a member-first philosophy while driving to the lowest net cost.

From optimizing biosimilar usage to delivering tailored solutions, Illuminate Rx empowers benefits advisors, employers, and members to make informed decisions while maintaining the lowest possible net cost. Illuminate Rx's commitment to clarity, control, and collaboration ensures a trusted partnership for sustainable, high-quality pharmacy benefit solutions.