

Preparing for a Pharmacy Benefit Manager Insurance Business Model

By Lawrence W. Abrams



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Numerous legal and legislative actions are in process alleging that the Big 3 pharmacy benefit managers (“PBMs”) – CVS Caremark, Aetna Express Scripts, and United Healthcare OptumRx – are not acting in the best interest of patients due to an opaque reseller business model.

The purpose of this column is to provide quantitative estimates of two transparent insurance business models as a private sector solution to the PBM problem.

1. a capitated premium model tied to a medical loss ratio (“MLR”).
2. a fee-for-service (“FFS”) model that includes a key performance indicator (“KPI”) of a per member per year (“PMPY”) delivered drug trend with risk sharing for deviations.

We think that our estimates could be a starting place for discussions among plan

sponsors, PBMs, and their legal counsel. PBMs operating under an insurance business model likely would bring them closer to being named fiduciaries subject to ERISA laws. This might be a net benefit to PBMs if ERISA status exempts them from the now cumbersome state laws and reporting requirements around their reseller business model.

It is time to move on from attempts to make the current PBM reseller business model more transparent. Time and time again the Big 3 PBMs have developed opaque alternatives to piecemeal 100 percent pass-through mandates. Time and time again PBMs have demonstrated expertise in finding loopholes in state government disclosure laws.

It is time to move on from the Federal Trade Commission’s attempts to rein in the PBMs. They are currently bogged down as one of the current Commissioners recused herself from a 2024 administrative complaint. Two other Commissioners recently were fired by President Trump, challenging a 1935 Supreme Court ruling in *Humphrey's Executor v. The United States*.

[2] The complaint itself is questionable due

to anecdotal evidence based only on net prices after rebates. [3,4]

The starting point for discussions around an insurance business model is a Big 3 PBM self-disclosed 8 percent long term average gross profit margin.[5] Based on reported drug trend delivered to plans, we use a \$1,200 to \$1,500 per member per year (“PMPY”) as the range for this KPI.

We propose that discussions of PBM insurance business models start with the following figures: (1) a fixed premium model with medical loss ratio ranging from 92 to 85 percent; (2) a fee-for-service model ranging from \$96 to \$120 PMPY with risk sharing of deviations from a contracted PMPY delivered drug spend.

These figures highlight the fact that a PBM delivered drug trend is more than ten times any PBM gross profit expressed as a FFS. The implications of this ratio are rarely discussed by PBM critics. However misaligned, the size of the Big 3 PBMs allows them to negotiate greater formulary rebates from Pharma, likely resulting in an overall lower total benefit cost than a small

transparent PBM. This is despite the latter offering a lower transparent FFS.

From the standpoint of compensating PBMs on a risk-adjusted basis, further research is needed into an 8 percent equivalent MLR and FFS. An insurance model should require PBMs to incur penalties for exceeding contracted delivered trend. The starting point for a MLR of 92 percent seems high when compared to the 85 percent MLR mandated by the Affordable Care Act for Medicare Part D plans.[6] As compensation for incurring increased risk, a MLR and FFS equivalent to 10 to 12 percent seems like a fairer starting point for discussions.

To continue to motivate the Big 3 PBMs to bargain hard with Pharma, and to design-in cost-effective utilization management programs, there needs to be some penalties for not meeting KPIs. At the simplest level, it could be something like the PBM retaining 50 percent of all delivered below contract and absorbing 100 percent of all delivered trend above contracted PMPY. Again, there needs to be a lot more research around fair trade-offs between contracted FFS and risk-sharing arrangements.

We conclude with some thoughts about likely changes to PBM management of plans underwritten by an insurance business model. Broadly, PBMs will switch to managing to achieve better outcomes as measured by PMPY trend instead of better gross profit margins.

Expect PBMs to increase utilization management programs like step therapy and quantity limits. Patient advocacy groups will not be pleased. They lobbied for more PBM transparency, and the result will be more utilization management than ever.

The danger here is that PBMs will have less incentive to manage drug adherence. There needs to be clauses in PBM insurance contracts specifying KPIs for adherence and patient well-being. There also needs to be terms of contracts preventing a year-end rush of additional utilization restrictions so as not to exceed contract trend.

The gross to net price bubble will shrink even further as only net prices matter, not gross rebates. Generics and low list price biosimilars will now uniformly be favored over higher list price brands that cannot prove superior efficacy. The recently

convoluted PBM scheme of private labeling biosimilars will be scrapped as the scheme's opaque margins no longer matter.

The financials of retail pharmacies likely will not improve under the PBM insurance model. PBMs still will bargain hard over retail pharmacy reimbursements in the desire to reduce the overall trend. The only saving grace for retail pharmacies is that PBMs will care only about prices of Rx regardless of where they are dispensed. Expect PBMs finally to allow retail pharmacies to dispense 90-day maintenance Rx if price competitive.

In terms of the design of rebate contracts, formulary bid menus will be simplified by eliminating opaque administrative fees and price protection rebates. On the other hand, incremental rebates for outright exclusion of named drug competitors will continue and outright formulary exclusions will continue. With the threat of a "world without rebates" diminished, the motivation for offshore rebate aggregators is gone.

Nominally, it is plan sponsors, not PBMs, who set copayment dollars and coinsurance

percentages. While not a utilization management technique, they do affect utilization. Operating under an insurance business model, PBM likely would be averse to any ratchet down of copayments and coinsurance unless offset by a higher KPI for delivered trend.

It is also interesting to note here that the vertical integration of the Big 3 PBMs with insurance companies has reduced the legal and actuarial expertise required to launch insurance-based pharmacy benefit plans. We think leaders will be companies historically dominated by the insurance business rather than the PBM business. We see United Healthcare and Elevance (formerly Anthem Blue Cross and Blue Shield) as leaders in offering insurance pharmacy benefit plans. In fact, United Healthcare's PBM OptumRx quietly launched in 2025 a so-called "Clear Cut Trend" plan that guarantees a PMPY drug trend.^[7] However, we could find no publicly available specifics such as trend guarantees, risk sharing or FFS.

Discussions about moving to a pharmacy benefit insurance model leads to thoughts about coverage for pharmacy and medical

drugs under a single medical insurance plan. Many biologics now are available as infusions or self-injectables with a single insurance code for the drug itself and two different codes for delivery. The prospects for disease management would seem better if there were no longer two separate plans for specialty drugs.

[1] There are no relevant disclosures pertinent to this piece. I have received no compensation or benefits from any party. I have a Ph.D. in Economics from Washington University in St. Louis and a B.A. in Economics from Amherst College.

[2] Jason Lalljee, *What to know about Humphrey's Executor, a case key to Trump's plans*, AXIOS, March 19, 2025 <https://www.axios.com/2025/03/19/humpreys-executor-trump-ftc-firing>.

[3] Dennis Carlton, *Using Data, Not Anecdotes to Analyze Criticism of Pharmacy Benefit Managers*, ANTITRUST CHRONICLE, January 20, 2025 <https://www.pymnts.com/cpi-posts/using-data-not-anecdotes-to-analyze-criticisms-of-pharmacy-benefit-managers/>.

[4] Lawrence W. Abrams, *A Discovery Plan for Pharmacy Benefit Managers' Collusion*, ANTITRUST CHRONICLE, January 20, 2025 <https://www.pymnts.com/cpi-posts/a-discovery-plan-for-pharmacy-benefit-managers-collusion/>.

[5] Dennis W. Carlton, et al., *PBMs and Prescription Drug Distribution: An Economic Consideration of Criticisms Levied Against Pharmacy Benefit Managers*, COMPASS LEXECON, October 2024, p.79-80, <https://compass-lexecon.files.svdcdn.com/production/files/documents/PBMs-and-Prescription-Drug-Distribution-An-Economic-Consideration-of-Criticisms-Levied-Against-Pharmacy-Benefit-Managers.pdf?dm=1728503869>.

[6] Center for Medicare and Medicaid Services, *Medical Loss Ratio*, 2024, <https://www.cms.gov/medicare/health-drug-plans/medical-loss-ratio>.



[7] UnitedHealth Group ,*OptumRx Announces New Pricing Model*, May 2024,
[https://www.unitedhealthgroup.com/newsroom/posts/2024/2024-05-optum-rx-clear-trend-guarantee.](https://www.unitedhealthgroup.com/newsroom/posts/2024/2024-05-optum-rx-clear-trend-guarantee)