

Pied Piper PBMs

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Healthcare is an emotive, politically sensitive issue. In the UK, the NHS is a political football weaponised on both sides of the aisle to boost poll ratings. Few of us can forget the daily press conferences during the Covid-19 pandemic, the clanging of pots and pans every Thursday evening to pay homage to healthcare workers, and the fanfare of the Nightingale hospitals which they had us believe were going to save us all, but were not fit for purpose, as we only found out after the panic subsided.

In the US, though healthcare is privately run and funded (by employers or government), it is equally politicised. Voters there tend not to not have much affection for health insurers, to whom they pay big monthly premiums which wipe out a decent chunk of their budgets. Worse still are “pharmacy benefit managers” (PBMs). Imagine falling ill, collecting your prescribed medication at the pharmacy counter – only to be told that you have a \$1,000 out-of-pocket “co-pay”. That scenario is common with so-called “high deductible” plans, which seem cheap – until you have to use them!

Though a PBM’s *raison d’etre* is not obvious, it is critical. They design and manage the pharmacy benefit plans for health plan sponsors to minimise costs, whilst maximising efficiency. They achieve these goals in four ways:

- By aggregating the buying power of multiple clients and customers, PBMs negotiate lower drug prices from “Big Pharma” than any individual client could do on their own. The so-called “rebate” is the difference between the “list price” (determined by Big Pharma) and the “net price” negotiated by the PBM. PBMs also leverage their scale to squeeze discounts out of retail pharmacies (such as Walgreens, CVS). The “spread” is the difference between the “wholesale price” of a drug and the (lower) actual price at which the PBM reimburses the pharmacy.
- Ensuring better clinical outcomes with protocols to improve medication adherence, therapy completion and clinical compliance.
- Designing drug “formularies” (preferred lists) thereby encouraging the use of the safest, most effective, and affordable medication. Pharmaceutical companies offer higher rebates for access to formularies of big PBMs.
- Ensuring better non-clinical outcomes, efficient claims processing, and data analysis. By way of example, it would inform prescribing doctors of medication which is therapeutically equivalent (Generics, Biosimilars) but cheaper. It also improves detection of fraud, waste, and abuse.

If you didn’t have a PBM, you’d want to create one as a counterweight to Big Pharma, whose *modus operandi* is simple: maximise profit over the decade of patent life. During that period, they are a price maker but volume taker. They set list prices based on what they believe the market will bear. After all, they are businesses, not charities! Price too low and they are leaving money on the table. Too high and there would be insufficient demand.

Big Pharma has (at congressional hearings) tried to deflect the blame for high drug costs to PBMs - in general, and rebates - in particular. However, drug companies set their own list price and decide themselves whether to offer a rebate on their drugs to gain access to formularies. Indeed, independent, non-partisan studies in 2019 by both the US Congressional Budget Office (CBO) and Centre for Medicare and Medicaid (CMM) acknowledged that rebates are an important tool to drive down drug costs, translating into lower premiums for plan members. That conclusion makes sense to anyone who has studied Porter’s five competitive forces in economics class, postulating that the bargaining power of customers increases as they become more consolidated.

That is not to say there aren’t issues with PBM “fee” structures. PBM fees are not transparent and are generated (in whole or part) in 3 ways - the latter 2 of which could create “negative incentives”:

- Administrative fee model, where the PBM fully “passes through” all negotiated savings (rebates and spread) and charges fees separately.
- Spread pricing model, where the client gives up some of the spread, in lieu of administration fees.
- Rebate model, where clients give up some of the rebates, in lieu of administration fees.

However, the negative incentives arise only where the PBM does not fully pass through the rebate (or spread) and not because of the rebate itself (which Big Pharma would have us believe). For example, where fees are contingent on rebate size, it could skew drug formulary choice. Suppose two drugs have the same net price, the PBM would be mis-incentivised to choose the one with the higher rebate. Equally, drug companies could conceivably hike their list price whilst keeping the net price flat, to increase the rebate as an incentive to a PBM to choose them for top tier on their formulary. For these (valid) reasons, the Trump administration commissioned the CBO and CMM 2019 studies into rebates. Ultimately the authorities created a “safe harbour” whereby rebates would only be allowed if they were fully passed through to consumers to cover out of pocket costs at the point of sale. No doubt, full “pass through” of rebates is where PBM regulation is headed in the future in the private sector too.

Currently clients have the choice of how they wish to structure “fees” whilst PBMs claim to be agnostic, with the profit margins of each model being comparable. It often boils down to how the client wishes to pay and the volatility they are prepared to bear. There is a misconception that PBMs generate significant profitability from rebates and spreads. If that were so, then it’s not obvious from PBM operating profit margins, which averaged just over 4% in FY22 - modest compared to Big Pharma which has margins north of 30%.

Ironically, the controversial rebates are the result of 1990’s anti-trust class action lawsuits, whereby retail pharmacy chains accused drug companies of giving PBMs more favourable pricing in the form of upfront discounts and refused to offer this to pharmacies, which they argued was illegal price discrimination. The case was “settled” but in the details of the agreement, drug companies agreed to offer retail pharmacies the same upfront discounts they offered PBMs. The rebate structure simply backends that discount.

Recently, there has been another flareup in negative sentiment towards PBMs, which has caused the derating of valuation multiples. There are currently two bills in the US senate:

- The Pharmacy Benefit Transparency Act which proposes to prohibit spread pricing (from pharmacies) which the PBM would satisfy if it passes through 100% of savings (“safe harbour”).
- The Prescription Pricing for the People Act which will direct the Federal Trade Commission (FTC) to issue a report and make recommendations to congress on improving transparency, preventing anti-competitive behaviour, and ensuring customers benefit from any cost savings (spreads and rebates).

Longer term, the destination seems clear. Rebates will only be allowed if they are fully passed through to the client or customer, which provides a “safe harbour”. Pass-through to the customer at the point of sale (rather than the insurer, employer) has the added benefit of capping out of pocket, “co-pays” (in the private sector). Spreads could be banned because they benefit big chains at the expense of small independent pharmacies. PBMs will have to provide more transparency and accountability to stakeholders (clients and customers).

PBMs have got the message loud and clear and aren’t waiting for regulators to act. Cigna already offers plans incorporating all these features. Should the regulatory landscape change, their existing contracts would allow for substitution to another plan, with negligible impact on earnings. Cigna has improved disclosure, going so far as to devote fifteen pages of their most recent quarterly filing to address some of the misconceptions.

Ultimately, so long as there is private sector administered health insurance in the US, a PBM’s raison d’etre is critical. Indeed, PBMs were born out of smaller insurers, outsourcing, and consolidating to generate savings and efficiencies. A local health insurer, or employer with significant market share in a state, would have a lot of bargaining power when negotiating rates with local hospitals because they are a big fish in a small pond. But there are fifty-two states in the US. They would be a guppy in the federal ocean when negotiating patented drug rebates with Big Pharma. Absent the US healthcare system becoming nationalised, the PBM pied piper must be paid, and they are agnostic as to how.



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