David Burda:

Welcome to the 4sight Health Roundup podcast, 4sight Health's podcast series for healthcare revolutionaries. Outcomes matter, customers count, and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, February 12th. We're still not talking about the Epstein files on today's show, but it seems everyone else's and for good reason. Instead, we're gonna talk about pharmacy benefit managers. There's been a lot of activity on the PBM front lately, and we're gonna talk about what it all means with Dave Johnson, founder and CEO of 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi, Dave. Hi, Julie. How you two doing this morning? Dave?

David W. Johnson:

Well, I've had quite a week. My wife, Terry, since she was a young girl has suffered from chronic kidney disease. And three years ago went on the transplant list and we got a call on Monday afternoon from Northwestern to offer a new kit, offer her a kidney. And, we took it, after some debate, packed up the cats, came to Chicago <laugh> and dropped her off at the hospital. She now has a new kidney and- Wow. <Laugh> ... Take, take her. I'm taking her home from the hospital today. So yeah. Wow. What a week. Great week. <Laugh>

Burda:

You know? Congratulations. I know.

Julie Murchinson:

That's amazing. Yeah.

Burda:

Well, I'll tell you, that sets the new bar for how you doing today,

Murchinson:
Right?

Burda:
Yeah. I was, you know, my paper was delivered on time this morning, so I was like, "Oh, that's pretty cool."

Murchinson:
<laugh> Wow. Yeah. Don't even ask me. I'm fine.

Burda:
Yeah, you're good. That's amazing. Yeah. <laugh> Oh, thank you. What can you do? Yeah. It's, it's great. Wonderful. Well, we'll, , we'll rush through this and get you on your way, man. You got, you gotta-

Johnson:
Yeah, I gotta put some clothes on.

Burda:
You gotta- <laugh> You better shave. I mean, she's gotta be a kidney, so you, you better be in tip top shape, Dave. Right, right.

Johnson:
All right.

Burda:
<Laugh> wow. All right. Before we talk about PBMs, let's talk about Abraham Lincoln. Today is Lincoln's birthday. He would've been 217. He was born in 1809. It's a state holiday here in Illinois. , Dave, you doing anything to mark the occasion? <Laugh> <laugh> Well, that question seems a little ridiculous now, but, I'll ask it anyways.

Johnson:

Well, we're, we're, we're doing a podcast and, I've got ... I'm at my desk in Chicago and I've got a bust of Lincoln to my right, reminding us to rely on the better angels of our nature. And if you and Julie will indulge me, since it's Honest Abe's 217th birthday, I'd like to honor what I believe was his greatest accomplishment, signing the Emancipation Proclamation and apply its lesson to healthcare. So Lincoln signed the, Emancipation Proclamation on January one, 1863. He'd been shaking hands all day for New Year's celebration at the White House, and he sat down to sign the document and his hand was trembling from shaking so much. And he actually waited for it to recover, because he didn't wanna look at all like he was trembling or, you know, unafraid to sign the document. He said, at the time, “my whole soul is in it and I have full and unambiguous commitment to human freedom." At the time, the North was losing the war, and Lincoln initially had fought the war to keep the Union together. We all know that. Pledging to end slavery gave a second and very powerful moral purpose to the North War efforts. It turned the tide, added 200,000 Black soldiers to the North Army, kept foreign nations from investing in the South and actually weakened the South's economy, so, might for right. So in ... Why am I talking about this other than it's Lincoln's birthday and greatest president ever? But we talk a lot about value in healthcare, and it's vitally important, but for me, combining value with universal health insurance coverage would give moral force to transformations, ground troops, like the three of us. And just so our listeners don't think I've had a Bernie brain implant, I advocate uni- universal coverage through a pluralistic model, not single payer. So I think, Honest Abe, would be in our corner on this one.

Burda:

Absolutely. All right, Julie, are you even gonna try to top that, in celebrating Lincoln's birthday in any way?

Murchinson:

I mean, I should just hang up now. <Laugh> It's gonna be the Dave Day. - I'm excited to watch a little Olympics. I haven't seen enough already, so that's my plan.

Johnson:

Yeah. Well, I'll just- By way- The ice dancers- The ice dancers got screwed, man. , They were so much better. I don't know if you agree with that, but man. Anyway, sorry.

Burda:

No, no.

Murchinson:

Well, I wanna support them from afar with some positive American vibes because they're certainly not getting it from our, our leaders.

Burda:

I'll just put a plug in for the Lincoln Museum in Springfield, Illinois. That opened in 2005, and if you haven't gone, I'd highly recommend it. And if you think our politics are rough and tumble now, the museum has this long hallway display of political cartoons of the day, when Lincoln was a candidate, and you'd be shocked. You know, politics have been ugly for a long, long time. So, well, today's topic is how will recent events surrounding PBM Shock Healthcare, and there's your transition. Let me run down a few headlines, then I'm gonna ask you what it all means, and here goes in chronological order. On January 27th, our friends at Trillion Health released what to me is the definitive piece of research on the role of middlemen like PBMs, group purchasing organizations, third-party administrators, and health insurance brokers. The report asks, "How much of PBM and GPO savings are actually passed to patients or payers? And how can policymakers and payers

ensure that Middlemen truly deliver cost savings to patients and providers?" A week later on February 3rd, Congress passed and Trump signed into law an attempt to address those questions. The Consolidated Appropriations Act of 2026 includes a number of reforms to PBM business practices. For example, the law now requires PBMs to pass along 100% of the rebates they get from drug manufacturers to the PBM's health plan clients. A day later on February 4th, the Federal Trade Commission announced an antitrust settlement with Express Scripts, one of the biggest PBMs that resolves charges that the PBM used anti-competitive and unfair rebating practices to artificially inflate the list prices for insulin that it required insurers to include in their formularies. Express Scripts agreed to stop doing that when cheaper equivalents are available. The FTC also required Express Scripts to relocate its own GPO Ascent from Switzerland to the US. That's very strange, but any way to pump up the jobs numbers, I guess. Dave, when you put it all together, what's going on here? Are we nibbling, around the edges with incumbent stakeholders or are we making real progress toward a consumer-driven healthcare system?

Johnson:

Oh, we're making ... This is real progress. Since I took extra time honoring Lincoln, I'll, I'll try to be quick on PBMs. Last week, we discussed the perfidity of the big three wholesale drug distributors, McKesson, Sincora, and Cardinal. There's a similar three-pronged oligopoly in the PBM marketplace, OptumRx, CVS Caremarks, and Express Scripts, as you mentioned, owned by Cigna. A- all three of these companies, are owned by big health insurance companies. They control as much as 80% of the PBM marketplace. They've been remarkably good at using their market leverage to play both sides against the middle, to profiteer at the expense of the American public. Manufacturers pay a price through high rebates to get included in each company's drug formularies. Payers and patients pay a price through spread pricing. Remember that term, where the PBMs pocket the difference between

what they pay drug manufacturers and what they charge, payers and patients for the drugs. Plus, there are all kinds of shenanigans to exploit their vertically integrated organizational structure. This is classic oligopoly and intermediary nonsense. It's literally money lenders in the healthcare temple. But just like what we discussed last week with wholesale drug distributors, the government and the marketplace are attacking PBM's quote unquote legalized profiteering on multiple fronts. And you mentioned a bunch of them, the Express Script settlement. Four of the 10s CMMI initiatives announced in December relate to, bringing down drug prices. TrumpRx has launched. Trillions brilliant analysis turns up to heat on PBMs. Transparent PBMs are all the rage, in getting market traction. The new law that, that Congress, passed, should eliminate spread pricing. And of course, our old Friends Civic RX continues to grow. As far as I'm concerned, healthcare dies in darkness. Shining a light makes these bad behaviors harder to practice. We ought to have spotlights on the PBMs twenty four seven. Drug prices are the fastest rising component of healthcare expenditure. It's time to reign them in, and I believe Lincoln would be proud if we do.

Burda:

absolutely. Thanks, Dave. , Julie, any questions for Dave?

Murchinson:

These rebate changes are a big deal for reasons that, you know, only the inside b- baseball people talk about, which is healthcare entities are addicted to the rebates as a revenue source. So which types of healthcare entities, do you think could be adversely impacted with these, you know, by real revenue decreases, if they choose to move to a transparent PBM or one of these models that's actually more straightforward transparent pricing?

Johnson:

So n- these rebates <laugh>, this is not a new strategy. It's been around. Criminals know how to, how to play their, use their leverage, even if it's technically legal. So PBMs are now, and rightly so under the microscopes, rebates and spread pricing need to disappear. This will hit PBMs the hardest, in their insurance, company overlords. Also it's gonna affect some of the drug manufacturers who've, you know, basically colluded with P- PBMs to get their, their drugs into the, into the formularies and into the marketplace. So, this will limit their ability to do that, hopefully eliminate their ability to do that. And if we can eliminate the rebate nonsense and the spread pricing nonsense, other than those two groups, the rest of American society will benefit enormously.

Burda:

Yeah. I mean, to rephrase, , Julie's questions, like, who loses when you stop taking kickbacks? <Laugh>

Murchinson:

<Laugh> It's basically everybody. I mean, plans- Right. ... And depending upon your structure- Yeah. ... You know, many providers, it's, , it's a, it's a real issue and kind of revenue reset for a lot of these organizations.

Johnson:

Right. Yeah. How, how did, how do the providers sort of benefit from PBMs, how do you think?

Murchinson:

<Laugh> Well, it depend- I think it depends upon their structure and whether they're taking- Yeah. ... Risk and the like, right? Yeah. But they, they also get rebates.

Johnson:
Right. That's right. Right. Yeah. That's right.

Murchinson:
Yeah. They can, right, depending upon- Yeah. ... Their relationship.

Burda:
Yeah.

Murchinson:
Yeah. Those who have health plans and,

Burda:
Right? Yeah. Yeah. Some- somebody's gonna have to do a lot of ciphering to figure this one out, right?

Johnson:
Well, that's, that's true, you know, because it all flows through the insurance companies. Yeah. And if they're, if they're playing the game and tied to providers, then, I was, I was thinking peer play providers, because they're usually on the outside looking in. Interesting.

Murchinson:
Yeah, no. Yeah. Yeah. Or the plan side.

Johnson:
Yeah.

Burda:
Yeah. Everybody's got a piece of the action. All right, Julie, it is your turn. What's your takeaway from all this activity? Does it create market

opportunities for someone other than PBMs to manage or lower drug costs for consumers and other payers?

Murchinson:

Yeah, I mean, there's several openings for non- PBM players to manage and lower drug costs. You know, this information advantage that PBMs have had and their ridiculous revenue model, as Dave pointed out, it's open game now. And the law doesn't, Dave, by itself guarantee lower prices, you know, at the counter, but, it breaks that opacity that PBMs have had and forces these rebate pass through and flat fee models, which, you know, I get excited about for the transparent, drug benefit managers. But there are others like employer coalitions, independent pharmacy networks, provider line models who can now, I think, compete on lowering drug costs for consumers and payers, which is awesome. And, you know, for the transparent PBMs and maybe others in the same category, like some of the carve out, you know, especially carve outs or, TPA models, they charge admin fees only. They can publish, you know, acquisition costs and, and the like, and they can compete on their service, which is something that we talk about here, right, and their clinical performance and not all of this rebate arbitrage. So, it's, it's redefining competition, in a lot of these markets. But I also look at, you know, the pharmacy chains, regional, independent pharmacy chains, and some of the tech-enabled pharmacy networks, they can contract directly, under more standard terms. They can integrate clinical services with some of these models, and, you know, they can develop network models that have better rates for steerage and quality. So there's something that can be done there, but I think probably, you know, I think a lot about, TrumpRX was, I guess, not announced, but defined last week. And a lot of people look at that as, okay, interesting marketplace, really cash pay kind of thinking, but the consumer-facing tools and no navigation, you know, apps or just approaches, they have opportunity here too. Like, they'll be able to surface better pricing to members in a way that can actually help steer members towards those better prices, kind of GoodRx

style, right? So they have the ability to, present plan-specific cost options and integrate prescribers and pharmacists to switch to lower cost options, and, you know, they could actually have an impact on how consumers think about buying, whether it's out of their pockets or out of their deductibles, or, you know, with their covered benefits. So there's a lot of opportunity to go around.

Burda:

Yeah. Yeah. I finally have something to work with and that, and that's great. Thanks, Julie. Dave, any questions for Julie?

Johnson:

Oh, I love it. Market versus medicine. <Laugh> This is one where market wins, right? Yeah, right. Yeah. Way to go, Julie, you nailed it. So I'm gonna ask you a fun but totally unfair question. Since we talked about, the wholesale drug distributors last week and the PBMs this week, I'm gonna ask you, which of the following three have caused the most damage to the American economy and why? The PBM oligopoly we talked about today, the wholesale drug, distributor oligopoly we talked about last, last week, or my constant, <laugh> refrain, Epic's fierce resistance to health data interoperability. <Laugh> Have fun. Go at it.

Burda:

That's a easy one for you, Julie.

Johnson:

Yeah. <laugh> Come on, Dave. You know, it's- , no honor among thieves, right? I, you know, it's just, -

Murchinson:

I wanna talk about Epic all day long. And if you had rephrased this question about has the potential to versus has been- Yeah. ... I would, I would go to town in Epic. But I mean, this PBM oligopoly has been crazy. Their scale and just the centrality of their pricing, like, they sit at this choke point of prescription drug, you know, the whole market for hundreds of millions of lives. Like, it's not just commercial, it's Medicare and Medicaid, and they influence everything. It's not just list prices, but it's formularies and, you know- Oh. ... Cost sharing, right? All the things we're talking about. So they have single-handedly, like, driven misaligned incentives. And, you know, i- hearing ... We actually did a round table last week with, ... So maybe I'm cheating <laugh> from that, but with, a bunch of chief pharmacy officers from health systems and health plans. And it was fascinating to hear their just real life stories about how because of the rebates, and higher list prices, you know, their decisions will be made about favoring drugs with higher rebates over cheaper, equally effective options. Like, that happens every day, all day long. And those costs get shifted to patients whose co-insurance and deductibles are, you know, based on those inflated prices. Like, it's hurting each and every one of us. And I mean, there will pay contracts and data just killed competition. So, from listening to these pharmacy officers, they struggle with doing ... They know what's right for the patient in so many ways, and they struggle because of how separated pharmacy can be from medical, certainly at the health system level. And if we wanna get to outcomes, it's another area that we have to think about merging in a really, you know, serious way. And, you know, one of our companies is a transparent PBM, has the first, you know, unified claims, platform for both pharmacy and medical claims. And who has that kind of data today without actually going through, like, massive spreadsheets to try to figure out what's really happening with a patient? So there's a lot of opportunity ahead.

Burda:

What consumers pay on any given day for their prescription meds, I think that's one of the greatest mysteries of life. You know, I recently helped a buddy of mine enroll in Medicare. You know, my cohort of friends is, turning 65, and he asked me how it's possible for him to have a zero monthly premium for his Medicare Part D drug plan. <Laugh> And I, I told him, "Don't worry someone's paying. We, you know, we just don't know who and how much." Yeah. So, -

Johnson:

Also, tell him not to get sick, - Right

Burda:

<Laugh>. Yeah. See, even a better, advice. That's great. Thanks, David. Thanks, Julie. Now let's talk about other big healthcare news that happened this week. Julie, what else happened that we should know about?

Murchinson:

Well, I didn't come today with news, but given, all the blowback on healthcare last year for sponsoring Super Bowl ads, I took note of ads this year, did you guys watch Super Bowl?

Johnson:

I did. Yeah. Sure. Pretty boring.

Murchinson:

I mean, the game was boring, but- Yeah. ... If you just started to count the healthcare ads, it became more fun. <Laugh> <laugh> Were you

Johnson:

Were you playing bingo? Healthcare bingo during the week. To

Murchinson:

Next year, I'm definitely gonna do that. <Laugh> I was shocked by, like, how straightforward Nova Nordisk was about their Waygovi pill. Like, it was just, like, why would you not take a weight loss drug? It was so over the top. And I mean, obviously Lily, Lily did their Zepbound and it was amazing to see Serena Williams, like, on a Rowe commercial. All the guys at our Super Bowl party were super excited about the Novartis, you know, finger-free prostate cancer screening, which was a hilarious ad. <Laugh> <laugh> But I did hear that there were three regional health systems, that's what I've counted so far. I'm sure there were so many more. But what I've heard from friends that NYU Langone ran another ad after all the blowback last year, I heard Hartford Healthcare ran an ad locally there. Sutter ran an ad locally in California. So seems like the regionals have found a, perhaps a, a kinder, gentler, cheaper pricing model for running a Super Bowl ad, but they're still doing it.

Burda:

Yeah. Well, that's a, that's a story that should be written, right? How many of those ads were healthcare related? I haven't seen-

Murchinson:

Yeah. There you go.

Burda:

That's a great idea.

Johnson:

Yeah. How much did they cost? Yeah. Exactly. Yeah.

Burda:

All right. Dave, what's your big healthcare news of the week that's not personal in nature because- <laugh>

Johnson:

Yeah, yeah,

Burda:

Yeah. That'd be tough to top. Go ahead.

Johnson:

Yeah. Well, thanks. Well, Julie, it's so funny that you mentioned the Super Bowl and the Super Bowl healthcare ads because far and away my favorite moment, even though I enjoyed Bad Bunny at halftime was the Mike Tyson ad that, came out against eating highly processed foods. I thought it, it was black and white. It was incredibly powerful- Yeah. ... Talking about him, himself and his sister and how much weight he'd lost, how his sister died. And it turned out that was sponsored by Maha, by our government. So, - Wow.

Murchinson:

Yeah.

Johnson:

Yeah. Yeah. So that's the good side of RFK. Yeah. And then what else happened this week? His FDA turned down or didn't even, wouldn't even investigate or put through the approval process Moderna's MRA-based flu vaccine-Which could save thousands of lives. I'm having trouble keeping these two thoughts in my head at the same time.

Burda:

Maybe there'll be enough pushback and, that'll get reversed. So, thanks, Dave. And thanks, Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. You also can subscribe to the

Roundup on Spotify, Apple Podcasts, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.