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Beyond the Middleman: The PBM Market at an Inflection Point

Pricing model shifts, regulatory pressure, and a real opening for
new platforms

- The Pharmacy Benefit Manager (PBM) market is at a tipping point. Long-standing structural issues are now translating into real dissatisfaction, sharper scrutiny, and market share shifts away from traditional models.
- Several trends are driving this shift at once: rapidly rising pharmacy spend, growing fiduciary and regulatory pressure, and increasing demand from plan sponsors for better pricing, greater transparency, and stronger service.
- Up-and-comers are making significant inroads, but incumbents still have real advantages, including procurement scale, broader bundles, and switching-cost protection, so disruption is unlikely to be immediate. Newer PBMs are breaking through where they can lower costs while maintaining or improving clinical outcomes and member experience.

Section 1: Understanding PBMs: Role, Evolution, and Structural Challenges

Pharmacy Benefit Managers (PBMs) sit at the center of a many-sided network connecting employers, health plans, pharmacies, drug manufacturers and patients across the U.S. prescription drug system. For most patients, they're invisible. But for employers, health plans, pharmacies, and drug manufacturers, they are often the most consequential counterparty in the system—shaping which drugs are covered, how pharmacies are paid, and what patients pay at the counter.

The most important takeaway from the diagram at the top of page 3¹ is that PBMs sit at the center of a complex web of relationships and flows in the outpatient drug system. PBMs help determine formulary access, pharmacy reimbursement, and other core economic flows between manufacturers, pharmacies, and payers. The complexity and multi-party nature of the industry creates a significant need for PBMs, but also opens the door to opacity and misalignment which is at the heart of the issues facing the industry today.

Because PBMs act as the "middleman" they have significant power over the ecosystem. This power is further

augmented by scale; key industry players have grown through a series of mergers, culminating with Cigna's acquisition of Express Scripts in 2018 for approximately \$67B.² As a result, Caremark, Optum and Express Scripts have emerged as the "Big 3," who collectively control approximately 80%³ of all prescription claims. This scale has created a formidable moat that is not easily disrupted, even with the emergence of modern technology and the significant technical debt created by mergers.

Additionally, PBMs have pursued significant vertical integration. All of the Big 3 have now been acquired by a payer. These combined entities have also built out their own mail order pharmacies, spun up Group Purchasing Organizations (GPOs), and acquired other related care delivery assets. These investments have enabled these large health plans to be the one-stop shop for their customers and hold promise of delivering a more integrated and perhaps lower cost healthcare experience. However, it also has reduced the independence of these important offerings, exacerbating the opacity and potential for misalignment inherent in the industry.

Figure 1: The U.S. Pharmacy Distribution and Reimbursement System for Patient-Administered, Outpatient Prescription Drugs

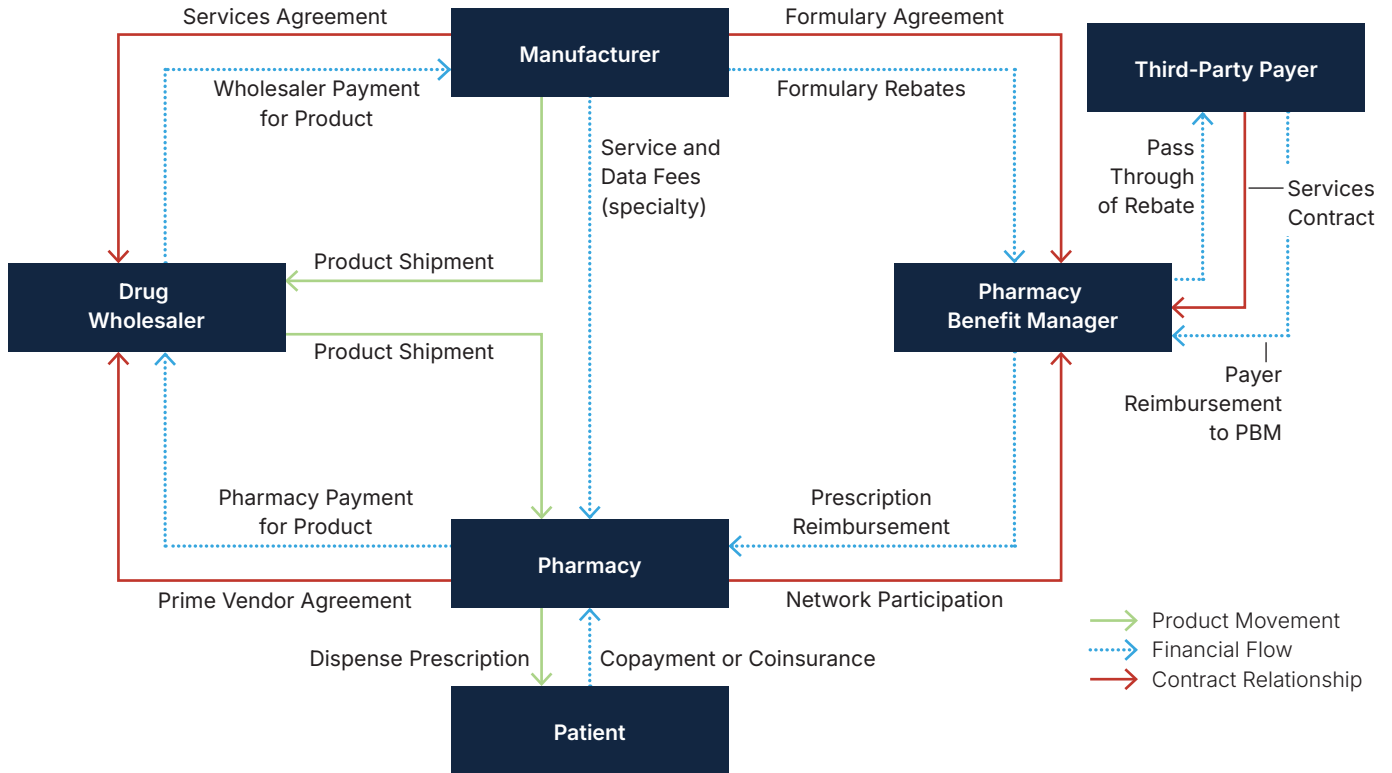


Chart illustrates flows for patient-administered, outpatient drugs. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.

Source: Fein, Adam J., *The 2016 Economic Report on Retail, Mail and Specialty Pharmacies*, Drug Channels Institute, January 2016.

PBM 101: Vertical Integration Expanded What PBMs Do—and How They Make Money

A PBM is the administrator and commercial negotiator behind a prescription drug benefit. Their responsibilities generally fall into five buckets:

- 1. Claims adjudication (“the plumbing”)**
Processing the prescription claim in real time.
- 2. Formulary strategy + utilization management (“the clinical levers”)**
Deciding which drugs are preferred and which face restrictions.
- 3. Pharmacy network contracting (“the distribution levers”)**
Negotiating pharmacy terms and steering volume through certain channels (retail, mail, specialty).
- 4. Manufacturer contracting (“the gross to net levers”)**
Negotiating rebates and fees for access and share.

5. Specialty pharmacy and related services (“the margin pool”)

Managing specialty assets and services as spend shifts toward complex, high-cost therapies.

How does a PBM make money?

PBMs make money both directly and indirectly from their customers through several pools:

Direct Customer Monetization

- **Administrative fees:** visible fees for running the benefit and processing claims.
- **Spread pricing:** charging the plan more than the PBM reimburses the pharmacy and keeping the difference.
- **Rebate and manufacturer economics:** retaining rebates or other manufacturer payments tied to formulary access and market share.

Indirect Customer Monetization

- **Owned-channel economics:** steering volume into PBM-affiliated mail-order, specialty, or other owned dispensing channels.
- **Generic, biosimilar, and specialty margin pools:** sourcing, dispensing, and reimbursement dynamics around high-margin categories.
- **GPO, vendor, and other service-layer fees:** economics can also sit outside the core claims transaction, in affiliated entities and adjacent fee streams.

A core tension in the PBM model is that some of the economics can be opaque and not always aligned with the client’s lowest net cost. Consequently, plan sponsors have shown growing interest in simpler contracts, greater transparency, and models with fewer conflicts of interest.

Section 2: The State of the Industry—A Market in Transition

For years, employer frustration with PBMs has been high, but real market change has been limited. Buyers complained about opaque pricing, weak service, and rising costs, yet the Big 3 retained share because switching was disruptive and their scale remained hard to match.

That dynamic now appears to be shifting.

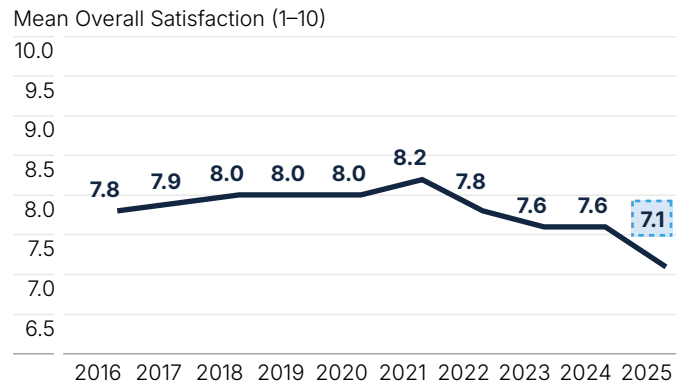
Recent employer survey data suggest satisfaction with PBMs has fallen to multi-year lows, with employers increasingly focused first on price and then on service.⁴

In our view, that long-building dissatisfaction is now converging with several more immediate pressures.

First, pharmacy spend has become much harder to absorb. Public survey data show pharmacy represented roughly 24% of employer healthcare spend in 2024, with employers expecting 11%–12% pharmacy cost growth heading into 2026.⁵ Employers are actively looking for ways to address pharmacy costs, and PBMs are the key lever.

Second, fiduciary responsibilities have fundamentally changed on the backs of the Consolidated Appropriations Act of 2021.⁶ Most importantly, the act gave plan sponsors, and therefore companies more access to PBM data and made them fiduciaries that are legally required under ERISA to ensure the plan is not overpaying and makes them liable for breaches of this duty. This change has not just been theoretical, but has resulted in numerous high-profile lawsuits against companies such as Johnson and Johnson, JPMorgan Chase, and Wells Fargo.⁷ These changes and headlines have put companies

Figure 2: 10-Year View of Overall Satisfaction with PBMs (n=260)



PBM Selection Factor	Rated Most Important
Pricing / Cost	68%
Member Experience / Customer Service	33%
Transparency	28%
Honors Guarantees and Commitments	24%

Percentages are not additive, as respondents evaluated different combinations of factors in a MaxDiff exercise

Source: Pharmaceutical Strategies Group, 2025 Pharmacy Benefit Manager Customer Satisfaction Report (Published Fall 2025)

on notice; as a result, many are changing their frameworks for evaluating pharmacy benefits, which is driving requests for proposals (RFPs) and switches.

Finally, reform has become more tangible, with states like Arkansas directly challenging elements of the vertically integrated PBM model.⁸ Perhaps more significantly, key provisions in the Consolidated Appropriations Act of

2026, enacted just in February of 2026,⁹ are poised to significantly curb more opaque profit pools tied to spread pricing and rebates, which will likely force traditional PBMs to monetize more via transparent fees, likely driving more RFPs and switches as customers confront these price hikes.

As a result, we are beginning to see genuine market movement. In perhaps the largest switch, Blue Shield of California restructured much of its PBM model away from CVS Caremark.¹⁰ Up-and-comers Judi Health, SmithRx and Rightway have landed Leidos,¹¹ UnitedAg,¹² and Eli Lilly,¹³ respectively, with all three clients switching to another large PBM. More broadly, the 2025 Pulse of the Purchaser survey found Big 3 PBM use fell to 61% from 72%, while transparent PBM adoption rose to 31% from 12%.¹⁴

Perhaps the clearest validation is coming from the incumbents themselves. Evernorth has moved toward a rebate-free model,¹⁵ and the market reaction showed this was meaningful: Cigna shares fell 17% in one day, erasing roughly \$14 billion of equity value.¹⁶ Additionally, CVS and Optum have both pushed cost-based reimbursement approaches.^{17,18} While it is unclear how these programs will be implemented and whether they will address all the underlying issues, there are clear indications that the Big 3 recognize the current models are untenable.

Section 3: What's Powering the Up-and-Comers (And What the Incumbents Still Do Better)

There is now a critical mass of emerging PBM and PBM-adjacent players making headlines and taking market share as employers go through a generational reassessment of their pharmacy benefits. Employers are increasingly looking for models built around the PBM industry's true north star—lower net costs, better clinical outcomes, and better service with minimal disruption.



What makes these newer players notable is not just that they are smaller or more transparent. It is that many of them are built on fundamentally different business models. Rather than relying on complex economics tied to spread pricing, rebate structures, or affiliated profit pools, they are generally positioned around more explicit fee models, modern technology, and a stronger willingness to pursue savings outside the traditional rebate paradigm. In our view, that makes them structurally better positioned to address many of the frustrations that have built up in the market.

At the same time, this is not a simple disruption story. Incumbents still retain major strengths—particularly scale, procurement leverage, and embedded relationships—which is why we believe market shifts are likely to be meaningful, but gradual.

Three advantages the up-and-comers have

1) *Simpler, more aligned business models*

- Many newer entrants are built around fee-based, pass-through structures that are easier for customers to understand and audit. That does not, on its own, drive lower costs, but it creates better alignment and gives these players more flexibility to pursue the lowest-cost pathway without the same economic conflicts embedded in legacy models.

2) *Greater willingness to attack waste across the system*

- Because economics are often less dependent on traditional PBM profit pools, challengers can be more aggressive in pursuing savings through alternative sourcing, channel optimization, biosimilars, tighter utilization management, and member navigation. These approaches can create meaningful savings even when incumbents retain procurement advantages.

3) *Modern technology and lower-cost operating models*

- Newer platforms are generally built on more modern infrastructure, with cleaner data, simpler configuration, faster implementation, and better member-facing tools. These platforms can lower the cost to serve, improve customer experience, and support the various savings programs. Additionally, modern platforms are better positioned to benefit from AI and automation that are clearly emerging.

Three advantages incumbents still have

1) *Scale and procurement leverage*

- Once a PBM clears the service and clinical bar, net price matters most. That is where incumbents still have an edge. Their scale gives them significant leverage with manufacturers and pharmacies, which remains especially important in large accounts.

2) *Vertical integration and broader bundling*

- Large PBM owners can bundle specialty pharmacy, care management, distribution, and broader payer

capabilities into one offering. For many buyers, especially larger ones, that bundled model can be economically attractive and operationally easier to manage.

3) *High switching costs and embedded relationships*

- PBMs are deeply integrated into plan design, member communications, clinical workflows, and pharmacy networks. Even when customers are dissatisfied, switching can feel risky and operationally complex, which continues to slow the pace of disruption.

While these advantages are meaningful and prevent a rapid loss of market share, we expect them to decay over time. With up-and-comers clearly taking share, the procurement advantage will erode. Up-and-comers are building more clinical capabilities to increasingly match what the PBMs can provide. And with new models becoming more proven and mainstream, companies are likely to become increasingly open to a new PBM.

Section 4: What We Look For as Growth Equity Investors

This is where the story becomes actionable. If the PBM market is shifting, where are the durable opportunities—and what separates a great business from a good narrative?

Our core belief: the next generation of PBMs will be the system of record for pharmacy spend—powering tools that lower drug costs, improve outcomes, and address one of healthcare’s biggest cost drivers.

The north star is simple: deliver the lowest net cost while maintaining or improving clinical outcomes and member experience. The best platforms do that through an aligned economic model, a modern operating system, and a growing set of tools that actually bend the cost curve.

Why we like PBMs as a business model

- Mission-critical and needle moving solution: PBMs sit at the center of a core healthcare workflow and help manage one of the fastest-growing categories of spend.
- Recurring, sticky revenue: once implemented, they are deeply embedded in claims, benefit design, clinical rules, pharmacy networks, and member communications.

- Attractive margins on net revenue: the best models can earn strong margins even if gross spend runs through at low margin.
- Working-capital / float dynamics: the model can benefit from favorable cash flow timing.
- Improving business quality with scale: as the platform grows, data, operations, distribution, and purchasing leverage can all improve.

Investable themes

1) *PBMs that can deliver lower net cost—without sacrificing outcomes or member experience*

We look for:

- Meaningful, provable savings on switch
- Lower trend over time, not just first-year disruption
- Clinical performance that holds up under scrutiny
- Seamless implementation and strong member experience

2) Clear tools and programs that drive and explain the lower net costs

Newer PBMs have demonstrated significant savings through product offerings such as:

- Formulary management built around net cost
- Faster generic and biosimilar conversion
- Smarter retail / mail / specialty channel steering
- Cleaner prior auth and reauthorization workflows
- Specialty programs that lower cost without creating new conflicts
- Member navigation that improves patient experience, reduces abandonment, and drives better utilization decisions

There will inevitably be others and we remain on the lookout for new and innovative programs.

3) Modern claims and benefit infrastructure (the “picks and shovels” layer)

We certainly want to see modern platforms in stark contrast to the cobbled together systems of the M&A driven incumbents. But a modern and proprietary system is insufficient unless it can drive tangible benefits including:

- Reduced manual processes historically associated with PBMs, transitioning the model to truly tech enabled and dramatically lowering the cost to serve
- Unified back-end data and workflows that unlocks all the cost savings programs
- Sophisticated yet clear customer-facing data and analytics that proves the ROI story
- Seamless customer onboarding and experience to drive engagement and strong references

4) Distribution unlock

The PBM market is highly brokered, particularly among larger employers. Brokers are sophisticated, yet historically risk averse, so cracking these channels is a powerful signal. And without these broker relationships, businesses will be capped and may even hit a growth wall. We are particularly focused on:

- Landing large blue-chip brokers that validate solution and support growth for years to come
- Expansion both into new brokers and with existing brokers
- ROI case studies from brokers to validate purported savings

What we diligence: proving the model is real

PBM businesses can look great on paper. The hard part is determining whether the advantage is structural, repeatable, and stronger with scale.

1) Where do you actually make money? Is the economic model truly aligned?

We want to see fee-based or other forms of monetization that create alignment, and are highly skeptical of the appearance of opaque profit pools in apparently “transparent” offerings

2) Do customers stay once they switch?

High retention and renewal rates matter. If the model is truly better, clients should stay, expand and reference positively after go-live

3) Does scale improve the business?

The best models should get better with growth: stronger data, lower operating friction, and high incremental margins

4) Can you implement reliably?

We look for smooth implementations, low disruption, and evidence that member and employer experience hold up in practice

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