How Pharmacy Benefit Managers Drive Up the Cost of Health Care

Analysis by Dr. Joseph Mercola February 01, 2025

STORY AT-A-GLANCE

- Pharmacy Benefit Managers (PBMs) evolved from simple claims processors into powerful health care intermediaries that control drug pricing and access through their relationships with insurers, pharmacies, and drug manufacturers. PBMs engage in "spread pricing" — charging insurers more than they reimburse pharmacies and pocketing the difference — while also steering patients toward higher-cost medications through "rebate pumping" arrangements with drug manufacturers

- The current health care system, influenced by PBMs, underemphasizes preventive care while promoting long-term drug dependency, as ongoing prescription management generates more reliable revenue than prevention or cures

- Independent pharmacies and rural hospitals struggle financially under PBM practices, facing delayed reimbursements, strict audit requirements, and complex negotiation terms that often force them to either close or sell to larger chains

- Three major investment firms — BlackRock, Vanguard, and State Street (the "Big Three") — have significant financial stakes across PBMs, drug manufacturers, and insurance companies, creating a web of interconnected financial interests

- Solutions include eliminating safe harbor rebate rules, expanding cash-pay health care models, separating PBM services from insurance companies, and implementing stricter regulations to improve pricing transparency

In the featured video, independent journalist Tucker Carlson interviews Brigham Buhler — founder and CEO of Ways2Well, a preventative care and health optimization platform — about how the health insurance industry works to keep us in poor health. Buhler's career in health care spans over 25 years, during which he gained significant insights into the pharmaceutical and medical device industries.

The rising cost of health care in the United States has become a heavy burden for many families who struggle to pay for essential services. Patients often end up navigating a maze of insurance requirements, denials, and opaque billing practices without understanding why their treatments cost so much. Pharmaceutical prices add another layer of difficulty, with insurers and other entities setting guidelines that determine access.

Pharmacy Benefit Managers, or PBMs, occupy a powerful place in this ecosystem. Initially created to simplify payments and negotiate prices, they have grown into influential brokers controlling which drugs are covered and how they are priced. Critics argue that these corporations operate behind the scenes, orchestrating deals that maximize their profits while pushing more expenses onto patients.

In other words, PBMs engage in hidden collaborations and pricing manipulations that fuel a system that is more concerned with corporate gain than with patient well-being. By shedding light on the complex financial incentives at play, Buhler helps us understand why each step of seeking medical care — from preventive screenings to essential prescriptions — feels increasingly draining on both wallets and morale.

He reveals an elaborate structure where individuals are funneled into long-term drug usage while basic preventative care is overlooked. Instead of ensuring affordability, PBMs exploit hidden markups and secret rebates to inflate insurance bills and keep people locked in chronic illness.

The Health Care Ecosystem Captured

For decades, researchers have warned that chronic disease often begins with lifestyle factors. A diet loaded with chemicals, refined sugars, and addictive formulas paves the way for obesity, metabolic issues, and diabetes.

The logical solution would be preventive care, yet the system consistently underfunds or blocks such efforts. Instead, the patient, already in poor health, is nudged into a cycle of drugs. In short, insurance companies profit from setting premiums and reimbursements that don't address the root causes.

PBMs connect drug manufacturers with insurance plans and pharmacies. By deciding which medications get favorable placement on insurance formularies, they have substantial power to shape treatment pathways. They operate as the "middlemen," determining reimbursement rates and adding costs that might not be obvious to consumers.

Critics argue that each link in this chain — from the chemistry of our fast-food culture to the mechanics of corporate insurance contracts — feeds long-term drug dependency. People hope doctors will rescue them with thoughtful interventions, yet many find themselves steered into prescriptions rather than genuine solutions. The net effect is a growing population locked into care that does little to uproot their actual problems.

The Rise of PBMs — Historical Context

Pharmacy Benefit Managers began as logistical helpers for insurance claims, intended to ease administrative burdens and secure group discounts on medications. In those early days, patients often benefited from lower prices and streamlined services, confident that PBMs were working on their behalf to rein in drug spending.

Over time, PBMs took a more pivotal role by merging with major insurers, pharmacies, and even drug companies. This expansion gave them the power to decide which medications appear on covered lists and how high co-pays would be set. BlackRock, Vanguard, and State Street, often called the "Big Three," poured investments into many PBMs, drug manufacturers, and insurance firms, linking them financially.

Regulatory agencies did little to keep up. Safe harbor laws, originally designed to allow certain discount arrangements, opened a door to hidden deals that few outsiders could track. Even government officials sometimes admit that they lack the tools or data to parse how PBMs arrive at final medication costs or distributions. This vacuum fosters multiple avenues for manipulative pricing.

While PBMs publicly champion themselves as experts in cost reduction, many inside observers contend that the real focus is leveraging secret rebates and inflated prices. The result is an enigma for consumers and health providers, who see rising expenses but cannot pinpoint exactly where the money goes. Without greater transparency, the underlying profit mechanisms of PBMs remain locked away behind bureaucratic layers.

Alleged PBM Fraud and Conspiracy Mechanisms

A key accusation involves "spread" pricing, where PBMs charge insurers a higher rate than they reimburse pharmacies, quietly pocketing the difference. Though advertised as normal operations, this method can inflate costs at every transaction. One high-profile investigation in Ohio's Medicaid system revealed how drastically these discrepancies boosted PBM revenues, convincing state officials that alternative approaches were more cost-effective.

A second alleged tactic is "rebate pumping." PBMs decide which drugs get priority coverage, sometimes favoring those with generous rebates from manufacturers. While patients believe they are following insurance rules, they might be guided toward medications that offer bigger profits for the PBM, even if more affordable or clinically superior options exist. This hidden arrangement undermines genuine market competition.

Formulary manipulation can steer entire populations toward high-cost drugs. When PBMs place lower-cost medications in less accessible tiers or require complicated approvals, patients rarely realize they've been nudged into pricier choices. Over time, these directed behaviors funnel billions into the PBM's revenue stream. Smaller drug makers, unable to provide large rebates, struggle to compete.

There is also the “deny, delay, depose” approach: denying coverage, delaying approvals, and deposing providers to wear down patients who challenge any claim refusal. The bureaucracy can be exhausting, compelling many people to simply accept PBM-dictated medications or give up on certain procedures. On top of this, forced mail-order mandates reduce local pharmacy competition.

Large PBMs often own chain pharmacies or mail services, ensuring yet another revenue channel. By dictating that some prescriptions must be filled through a mail-order affiliate, they tighten their hold on supply routes. Collectively, all of these maneuvers burden the sick while generating steady corporate windfalls.

Real-World Consequences

Small, independent pharmacies are the first to feel the weight of these arrangements. They operate on narrow margins, often waiting extended periods for reimbursement. Regular audits can penalize them if co-pays or deductibles aren’t strictly collected. Many find the financial strain overwhelming and convert to cash-only practices or sell to bigger chains aligned with PBMs.

Hospitals, especially those in rural or underserved areas, also struggle. Heavy dependence on insurer contracts means they must accept the terms PBMs set, even if that means late or partial payments. The complexity of negotiations can leave hospitals uncertain of actual reimbursement amounts for surgeries and treatments. Over time, these uncertainties hamper hiring efforts, infrastructure updates, and overall quality of care.

Patients shoulder the brunt of it. Co-pays and deductibles, often determined by PBMs in tandem with insurance companies, can skyrocket. A single major procedure might leave someone battling endless paperwork, fighting denials, or searching for a distant “in-network” specialist. Over time, chronic disease management grows more expensive, sometimes to the point where even standard treatments become a risky financial gamble.

Though high costs might be justified as byproducts of progress, critics point out that patients who need life-extending therapies can be denied based on invisible profit motivations. These denials or lengthy pre-authorization demands can dangerously delay critical interventions. Overall, the system keeps many people in a perpetual state of fear, worried about the next surprise bill or approval hurdle.

Chronic Disease, PBMs and the Incentive to Keep Patients Sick

The troubling notion is that PBMs profit when people remain in long-term treatment. Managing diabetes, heart disease, or recurring infections, for example, yields continual revenue from drug sales, hospital stays, and follow-up visits. If earlier screenings or lifestyle guidance could prevent these conditions, insurers and PBMs would lose a recurring income stream. Thus, the system subtly discourages prevention.

Preventive care often gets labeled as "non-essential." Insurance companies may only cover minimal checkups or simplified blood panels rather than the deep investigative screenings that might detect cancer cells or metabolic shifts. Doctors who push for thorough evaluations can face audits or claim denials. This approach effectively steers clinicians away from digging into root causes and keeps them dispensing short-term fixes instead.

Chemotherapy, obesity medications, and specialized therapies offer further insight. PBMs choose which oncology drugs or weight-loss injections land on the top tier of coverage, frequently guided by favorable rebate structures. For instance, prescribing an expensive cancer drug is more attractive to PBMs than promoting cost-effective solutions or advanced screenings.

By focusing on maximum reimbursement rather than clinical optimization, PBMs foster a system that prizes medication adherence over true health. Even potential cures or preventative interventions fade in importance compared to the reliable flow of payments from chronic prescriptions.

Media Collusion and Lobbying

One of the biggest shields for PBMs lies in corporate media's dependence on pharmaceutical advertising. Huge budgets flow from big pharma and PBMs into television networks, newspapers, and digital platforms. Investigative reporters who try to expose PBM tactics might find their stories curtailed. Advertisers dislike unfavorable coverage and influence editorial choices that help them maintain their revenue streams.

Lobbying piles on another layer of insulation. PBMs, insurers, and drug manufacturers invest massively in shaping legislation. They aim to preserve safe harbor laws and defend the complexity of rebate arrangements. Officials, short on time and expertise, often accept industry talking points that claim PBMs deliver broad discounts. Meanwhile, advanced data remain hidden under confidentiality clauses, preventing thorough oversight.

Alternative or cost-effective providers become immediate targets for negative coverage or red tape. Compounding pharmacies, which customize medications more cheaply, face extra scrutiny and high-profile condemnation if any recall occurs. At the same time, preventive clinics that promote advanced blood tests and deeper lifestyle assessments are dismissed as "non-traditional," leading many patients to doubt their credibility.

Without a major shift in how media and lobbying are handled, PBMs will likely continue operating in the shadows, benefiting from the current structure. Even well-intentioned legislators who propose reforms may confront a lobbying wall that distorts or dilutes their efforts. As long as the press echoes PBM-friendly narratives, the public remains unaware of the mechanics that inflate drug costs and stifle real medical innovation.

How to Break the PBM Grip

Some argue that the fastest route to PBM accountability is legislative reform. Eliminating safe harbor rebate rules could force full disclosure of every cent collected from manufacturers. If the public saw how big the discrepancy was between list prices

and actual reimbursements, the outcry might pressure policymakers to demand fairer pricing structures.

Others propose expanding the cash-pay model so that pharmacies and clinics can sidestep PBM-dictated reimbursements. Direct primary care clinics, which ask for a monthly membership rather than rely on insurance, show promise. Patients pay transparent fees, sidestepping the labyrinth of co-pays, claim denials, and lengthy authorization steps.

Critics say it may limit coverage for catastrophic events, but supporters argue it fosters clearer, more compassionate medical relationships.

Another idea is to separate PBM services from insurance altogether. Insurers could be barred from owning or partnering with PBMs, avoiding the vertical integration that squeezes out independent competitors. If drug costs were set in an open marketplace, free from hidden rebates, local pharmacies might compete on actual prices, improving affordability for the average consumer.

Finally, bold political will is essential. Some leaders talk about dismantling PBMs, a move that could reorder the entire pharmaceutical ecosystem. Opponents decry it as radical, but the current system is unsustainable. If enough people demand an end to covert backroom deals, PBMs could be dethroned from their gatekeeping position, placing health care decisions back into the hands of doctors and patients.

Parallel Issues — Chronic Disease, Food Industry and Metabolic Health

The PBM conversation intersects with a larger reality: a culture of processed foods and tobacco-inspired marketing that has ravaged public health. By engineering addictive flavors and packaging, corporations profit from driving individuals toward chronic ailments like diabetes. PBMs then profit further from long-term prescription management. This chain of enticements traps many in endless cycles of medication.

Preventive medicine would disrupt this pattern, but PBMs have little reason to champion comprehensive screenings. If fewer people develop metabolic disease, the volume of prescription-based revenue drops, undermining the financial base of PBM operations. In short, more robust screenings, especially for heart disease and early-stage cancer, would save lives but erode corporate balance sheets.

The good news is that many patients are now starting to rebel and opt for things like direct-pay blood tests, customized diets, and health care providers who embrace functional principles — all of which weaken the PBM chokehold. By proactively caring for your body, you reduce the likelihood of becoming a chronic customer for expensive prescriptions.

The goal, in essence, is to break the cycle that pairs hidden market incentives with manufactured disease.

Call to Action

PBMs exert a profound influence on who gets what medication and at what cost, yet much of their work is veiled from public view. As explained by Buhler, this system, anchored in concealed rebates, inflated average wholesale prices, and manipulative formulary structures, is responsible for skyrocketing health care costs. Patients feel the sting through insurance premiums, high deductibles, and arbitrary claim denials.

By peeling back the layers, we see a troubling alliance between PBMs, major insurers, and media outlets — a web that thrives on keeping Americans in long-term prescription cycles. Though reforms have been proposed, progress is stalled by extensive lobbying and carefully crafted narratives that depict PBMs as cost-saving heroes. Still, a rising movement demands real transparency and policy changes that might reset the playing field.

Shifting the balance of power involves both political and individual actions. For example, we need to urge lawmakers to abolish secret rebate loopholes and consider stricter regulation of PBMs. On a personal level, you can also explore direct-pay health care

models, improve your knowledge about preventive medicine, and support local pharmacies that sidestep the PBM structure.

As noted in the featured interview, a failure to confront these issues leaves us with ever-increasing premiums, minimal improvements in chronic disease outcomes — and minimal trust in the institutions supposed to protect public health. But if genuine policy efforts and grassroots initiatives merge, we can begin to reclaim control. The prospects for cheaper drugs, renewed primary care, and a greater focus on prevention could then become more than just a distant hope.