When the shark meets the pediatricia what the Cuban-Conway debate revea about healthcare structural problems

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Key Takeaways:

- OptumRx claims 100% rebate passthrough starting in 2024, but implementatio details remain murky

- The gross-to-net bubble creates a tax on sick patients during deductible phase

- Multiple pricing tiers for identical drugs persist despite cost-plus rhetoric

- Independent pharmacy reimbursement uses NADAC, which may not reflect act acquisition costs

- Vertical integration creates alignment problems that no amount of efficiency c solve

- Both speakers agree hospitals and pharma list prices are the real cost drivers

- Cash pricing consistently beats insurance pricing across the system

- Deductible crediting for out-of-network purchases remains a policy battlegrou

Setting the Stage

The Hopkins forum that brought Mark Cuban and Dr. Patrick Conway together public debate on payment and delivery innovation turned into something more valuable than either participant probably intended. This was not a polite acaden discussion. Cuban, who runs Cost Plus Drugs and has made transparency his cru faced off against Conway, CEO of Optum, the quarter-trillion-dollar health serv behemoth that includes OptumRx as one of the three dominant PBMs in Americ Professor Ge Bai from Johns Hopkins moderated, though moderating might be t generous a term for what became a rapid-fire cross-examination.

The basic facts here check out. Optum reported 250 billion in revenue for 2023, making Conway's characterization accurate within rounding. OptumRx is indeed of the big three PBMs alongside CVS Caremark and Express Scripts, collectively controlling roughly 80% of the prescription market. Cuban launched Cost Plus I in 2022 with a transparent pricing model showing acquisition cost plus 15% mar plus pharmacy fees. What neither mentioned is that Cost Plus primarily focuses generic and specialty generic drugs, with limited brand coverage because manufacturers have largely refused to contract with them, a point Conway would dance around.

Conway came prepared with talking points about clinical programs, rebate passthrough, and cost-based reimbursement for independent pharmacies. Cuban

came prepared to challenge every single claim with the kind of specificity that o comes from actually trying to sell drugs to employers who have OptumRx contra The result was a transcript that reveals more about how the pharmacy benefit management system actually works than a dozen white papers or congressional testimonies.

What makes this debate valuable for health tech investors and entrepreneurs is the spectacle, though there was plenty of that. The value lies in watching two sm operators with different business models argue over specific mechanisms. When Cuban asks why patients pay different prices for the same drug, or why OptumR needs price comparison tools if everything is already at net price, these are not g questions. They are fundamental questions about market structure that every fo building in the pharmacy space needs to understand.

The Core Disagreement on Rebates an Net Pricing

Conway opened by explaining that OptumRx negotiated over 50 billion dollars i discounts and rebates last year, and that OptumRx is the only large PBM that announced 100% rebate passthrough to clients. This sounds straightforward unt start pulling the thread. The 50 billion dollar figure is likely accurate based on OptumRx's market share and total rebate dollars in the system, which the USC Schaeffer Center estimates at around 240 billion annually across all PBMs. The about being the only large PBM with 100% passthrough needs more scrutiny. Pr Therapeutics announced a similar model earlier, and several smaller PBMs like Navitus have operated on full passthrough for years. What Conway likely means OptumRx is the only one of the big three to announce this publicly, which is technically true but misleading about the competitive landscape.

Cuban immediately went there, asking about MSR, the group purchasing organi that OptumRx created as a subsidiary, technically based in Delaware but with pe in Ireland. The structure matters because it determines where value accrues and captures it. MSR, or MedImpact Strategic Resources, is real and the Delaware-Ir

structure is real. This setup is common for intellectual property and licensing arrangements that benefit from Irish tax treatment, though OptumRx would arg location is about accessing European biosimilar markets.

Cuban's question was direct. If MSR negotiates rebates but no longer keeps any money, what is MSR for? Conway explained that group purchasing organizations negotiating power to get lower prices, which is true in healthcare and outside healthcare. Every contract coming up for renewal moves to the 100% passthroug model, and they have already moved over 95% of contracts. The 95% claim is impossible to verify without access to OptumRx's contract database, but the tim Conway describes, announcing in January 2024 and implementing over a three to year contract cycle, means many employers signed contracts in 2021-2023 that w not expire until 2024-2027. So the 95% figure would only be plausible if OptumR offering contract amendments or buyouts, which they might be doing to get competitive advantage while other PBMs have not made this move.

This is where the information asymmetry becomes structural rather than incider Cuban pointed out that nobody is allowed to publish these contracts, so differen employers cannot really compare notes. This is absolutely true. PBM contracts routinely include non-disclosure provisions that prevent employers from sharing pricing terms even with their consultants in some cases. The FTC launched an in into these gag clauses in 2022, and several states have passed laws against them, they remain common in practice. Conway deflected by talking about client satisfaction scores, claiming 98% renewal rates and satisfaction rates above 90%. These numbers are suspiciously high and likely come from OptumRx's own surv rather than independent measurement. For context, net promoter scores in healt average around 30-40, so a 90% satisfaction rate would put OptumRx in the top percentile of all healthcare services, which strains credulity.

The real issue emerged when they got into gross versus net pricing during the deductible phase. Professor Bai clarified that the rebates create a difference betv gross price and net price, and patients face cost sharing based on gross price, no post-rebate net price. This is the fundamental problem with the rebate system a is exactly right. A drug might have a WAC of 600 dollars, a net price after rebate

300 dollars, but a patient in their deductible phase pays the full 600 dollars. The employer gets the 300 dollar rebate months later, but the patient never sees it. Conway explained this as a benefit design choice that employers make. This is technically true but deeply misleading. Employers make benefit design choices, b they make those choices based on what their PBM and consultant recommend, a the standard approach has been to base cost-sharing on list price because it max rebate dollars.

Cuban pushed back hard. Why charge full WAC price to somebody during the deductible phase? Is it the choice of the employer, or does OptumRx just let it h even though the patient is their customer? This question gets at the agency prob The patient is the end user, but the employer is the customer who pays OptumR OptumRx optimizes for what the employer wants, and historically employers hav wanted maximum rebates to fund their overall benefit costs. The fact that this m drugs unaffordable for sick employees has been treated as collateral damage.

Conway's answer revealed the structure. They serve over 5,000 unions, governme employers, and payers. Those entities have benefit designs they put in place on c and deductibles. OptumRx works with them on those benefit designs, recommer lower deductibles and copays in the zero to five dollar range. But in terms of gro net, they negotiate a net price on behalf of customers, and OptumRx has said the customer should never pay more than that net price. They put that into their sys 100% of the time. This claim is new and significant if true. Conway is saying tha some recent date, OptumRx has configured their adjudication system so that pat cost-sharing cannot exceed the post-rebate net price even during the deductible phase. If this has actually been implemented across all clients and all claims, it v be a major change. However, the claim is impossible to verify without access to c data, and there are reasons to be skeptical.

Cuban asked if that includes the rebate GPOs. Conway said yes, all the way thro the GPOs. This suggests the net price calculation includes all rebates from all so including MSR. Cuban then asked if MSR makes no money anymore and is of no and will be closed. This is the kill shot question. If MSR negotiates rebates but k none of the money and passes everything through, and if patients never pay mor

net price, what is MSR's function? Conway clarified that the negotiation from th GPO saved people over 50 billion dollars last year, and those rebates are passed through to clients. The question about why MSR exists as a separate legal entity Delaware and Ireland if it is just a passthrough remains unanswered.

The exchange revealed a basic tension. If all rebates are passed through, what is point of rebates? Why not change the whole system? Conway's response was tell you had no rebates today, if you snapped that wand immediately, you would tran hundreds of billions of dollars from employers and health plans to pharma comp This argument treats the rebate system as a necessary counterweight to list price rather than as a contributor to the problem. The logic is that pharma companies high list prices, PBMs negotiate rebates, and without rebates the high list prices would remain but employers would pay the full amount. This is probably true in short term but ignores the fact that rebates are why list prices are high in the fir place. Manufacturers raise list prices to fund rebates, creating a spiral that only benefits the most rebated drugs and penalizes patients during deductible phases

Cuban's counterargument was that employers are supposedly smart enough to le their sickest employees create rebates, but not smart enough to work with their GPOs to negotiate with brands. This is a fair point. Self-insured employers with thousands of employees could in theory band together and negotiate directly wit manufacturers, cutting out the PBM middleman. The reason they do not is a combination of complexity, expertise, and the fact that PBMs provide services be rebate negotiation including formulary management, prior authorization, claims adjudication, and mail order pharmacy. Unbundling these services is possible bu requires more sophistication than most HR departments have.

Conway said a 50-person employer group is not going to negotiate similar deals all pharmaceutical companies in America. This is obviously true for a 50-person group, but Cuban was not talking about 50-person groups. He was talking about self-insured employers and coalitions of employers. Conway's point is more valic small employers who buy fully-insured plans and have no bargaining power at al Cuban said what they will do is work with Cost Plus Drugs once Cost Plus is all to work with big brands, which OptumRx is preventing. This claim needs unpac

Cost Plus has tried to contract with brand manufacturers and been largely unsuccessful. The manufacturers say they will not contract with Cost Plus becau Cost Plus publishes prices, which would undermine their rebate negotiations wi PBMs. Cuban believes PBMs are telling manufacturers not to work with Cost Pl This is plausible but hard to prove without discovery in an antitrust case.

Conway said they have been asked multiple times whether an employer can work Cost Plus, and they say yes. This is where Cuban called bullshit. The truth is pro somewhere in the middle. OptumRx likely does not formally prohibit employers also contracting with Cost Plus, but they also do not make it easy. An employer v an OptumRx contract could in theory tell employees they can use Cost Plus for c drugs, but getting those claims to count against the deductible and out-of-pocke requires OptumRx to process the claim, and there is no standard way to do this. Conway is technically correct that they do not prohibit it, but Cuban is correct t does not actually work in practice.

The challenge was specific and public. He said he would go to all the OptumRx p Cost Plus has talked to and ask to be added to their network, because Dr. Conwa they can. Conway tried to stay positive, talking about how Cost Plus has develop company trying to solve a challenge and OptumRx welcomes innovation in the marketplace. But the distinction he drew was between a niche solution largely in generics versus a comprehensive solution that negotiates the lowest net price for entire population with clinical programs. The niche versus comprehensive frami self-serving but contains some truth. Cost Plus has around 2,000 drugs, mostly generics and specialty generics. OptumRx manages formularies with 3,000-plus including all major brands. For a patient with complex conditions taking multip medications, Cost Plus cannot be their only source. The question is whether Cos should be available as an option within an OptumRx benefit design, and Conway avoiding saying no explicitly while also not saying yes in a way that would enable

Biosimilars, White Labels, and the Question of Multiple Prices

The biosimilar discussion opened another window into how the system actually works. Cuban asked why there are two different versions of biosimilars, one low and one high WAC, one with high rebates and one with lower or no rebates. This not an academic question. The existence of multiple price points for therapeutic equivalent drugs suggests that the pricing is being optimized for something othe than making drugs affordable at point of sale. Cuban is describing a real phenomenon. Biosimilars come to market with different pricing strategies. Some launch at 15-30% below the reference product with significant rebates. Others la at 80% below with minimal rebates. PBMs have historically preferred the high-li high-rebate versions because they generate more rebate revenue, even though th list versions would be cheaper at point of sale for patients.

Conway said biosimilar adoption is going up in the US, and net prices are going 80 to 90 percent for drugs like Humira and Stelara. OptumRx welcomes that. Th adoption numbers are true. Humira biosimilars reached about 60% market share within months of launch in 2023. The net price reductions are also real but misleading. Net prices for Humira dropped significantly, but that is because the reference product Humira had a list price around 7,000 dollars per month. A 90 price reduction means the biosimilar costs 700 dollars per month, which is still expensive, and patients in deductible phases were initially paying list prices arou 1,500-2,000 dollars per month for the biosimilars before cost-sharing adjustmen kicked in.

But Cuban was not asking about adoption rates or net price trends. He was aski why multiple versions exist. Conway said they do not force multiple versions, an manufacturer sets the list price. Cuban clarified he did not say force, just why. Conway said manufacturer. This back-and-forth reveals the complexity. Manufacturers do technically set list prices, but they set those prices in respons what PBMs say they will cover. If a PBM says we prefer high rebate products, manufacturers will launch high list price high rebate versions. If a PBM says we prefer low net cost regardless of rebate, manufacturers will launch low list price versions. The prices are set by manufacturers but in response to PBM incentives

Cuban pushed back. OptumRx white labels biosimilars, having manufacturers m them through companies like Navalia. This is true. Navitus operates a white labe biosimilar program where they contract with manufacturers to produce biosimil that Navitus brands and prices. OptumRx has a similar arrangement. The white allows the PBM to control the pricing strategy rather than just responding to wh manufacturers offer. So the simple question is why do you have drugs that are hi WAC, low WAC? Why do patients pay different prices for the same drug ever?

Conway laid out four principles they adhere to for biosimilars. Clinical equivale supply, and lowest net price. They do not care about high WAC or low WAC. Th want the lowest net price for customers. If this is true, OptumRx should exclusiv use the low-list biosimilar versions because those would have the lowest net pric The fact that they use multiple versions suggests either the claim is false or thei definition of lowest net price includes rebate value that goes to the employer rat than just the price the patient pays.

Cuban asked again if they have multiple versions. Conway said they do not manufacture drugs. If a manufacturer, and then he stopped, trying to figure out Cuban was asking. Professor Bai clarified the question. If there is a very cheap biosimilar, but OptumRx has its own labeled biosimilar, does OptumRx take the one? Cuban said that was not his question. He wanted to know why there are mu prices for the same drug for different patients. This is the core question. If two patients take the same biosimilar, why would they pay different amounts? The an could be different benefit designs, different pharmacy channels, different cost-sh phases, or different contracted prices in different networks. All of these are real phenomena.

Conway said manufacturers set the price, and OptumRx delivers the lowest net p Cuban said he talks to the same manufacturers. OptumRx goes out to bid, saying will have this expected volume, what is the best price you can give us? The manufacturers do not set prices unilaterally. OptumRx negotiates them. This is obviously true for biosimilars where OptumRx is running a competitive bidding process. Conway tried to clarify that some examples Cuban mentioned, like Lilir were different companies, not OptumRx. Lilinovo is a Cigna Express Scripts init

so Conway is correct about the attribution. But he acknowledged OptumRx does white label manufacturers that set their list prices, and what OptumRx does with customers is ensure they get the lowest net price clinically equivalent drug.

Cuban asked if they just pay manufacturers whatever they ask for. So the Stelara biosimilar is 3,000 dollars because the manufacturer wants it to be? Conway said manufacturers set a list price, OptumRx negotiates a lower net price, and biosim did lower the net price for consumers when they came out. This is all technically but evades the question about why list prices matter if OptumRx only cares about prices. The answer is list prices matter because they determine patient cost-shar during deductible phases and because they provide room for rebates. A drug with 3,000 dollar list price and 2,000 dollars in rebates has a 1,000 dollar net price. A with a 1,000 dollar list price and zero rebates also has a 1,000 dollar net price. OptumRx claims not to care which version they use, but their behavior suggests prefer the high-list-high-rebate version.

This exchange matters because it shows how vertical integration muddles accountability. OptumRx negotiates with manufacturers, but United sets benefit designs, and OptumRx serves United plus 99 other payers. The incentives point different directions depending on which hat Conway is wearing. When he talks a comprehensive solutions and clinical programs, he is talking about OptumRx. W he talks about premium pressure and benefit design, he is talking about payers. he talks about white label biosimilars, he is talking about manufacturers. The fa that Optum touches all these parts of the value chain is either the solution or th problem, depending on your perspective.

The Independent Pharmacy Dilemma

Cuban raised the question of why OptumRx does not go to the big three wholesa and ask them to stop buying at WAC or NADAC and move to list price on everyt they do, which would also help local pharmacies. This question reveals some confusion about how drug distribution works. Wholesalers buy from manufactu WAC minus chargebacks and rebates. They sell to pharmacies at WAC or a sligh

markup. The pharmacy's acquisition cost depends on their contract with the wholesaler, which is usually WAC minus some percentage based on volume. NAI is not a price pharmacies pay, it is a survey-based estimate of what pharmacies p average. Cuban's point is that if wholesalers bought at net price and sold at net p it would eliminate the spread between acquisition cost and reimbursement.

Conway claimed they already did that. Cuban said no, you did not. Conway said we did, describing it as cost-based reimbursement for brand and generics rolled to over 80% of independent pharmacies. They even had a press release with independent pharmacists talking positively about OptumRx. This needs fact-checking. OptumRx did announce a community pharmacy cost-plus reimbursem model in January 2024. The announcement said it would reimburse pharmacies a NADAC plus a dispensing fee, which is cost-plus if NADAC actually reflects cos 80% rollout figure is plausible if they are only counting pharmacies they actually contract with, but many independent pharmacies are not in the OptumRx netwo all, so the denominator matters.

Cuban asked what they are using as cost. Conway said standard cost measures li NADAC. Cuban asked if NADAC is the actual cost paid when wholesalers that w not work at a net price have GCRs. He pointed out that independent pharmacies not even know what their cost is going to be because of generic compliance ratio chargebacks. This is absolutely correct and shows Cuban understands pharmacy economics better than Conway is giving him credit for. NADAC is based on pha surveys, but pharmacies report their invoice price before generic compliance rat adjustments and before chargebacks. So a pharmacy might buy a generic for 10 dollars, report that to NADAC, then later get a 2 dollar chargeback because they not hit their GCR target, making their actual cost 12 dollars. If OptumRx reimb at NADAC plus 2 dollars, the pharmacy gets 12 dollars in revenue against 12 dol cost, which is breakeven not cost-plus.

So when Conway says true cost is NADAC, it is not true cost, and you can still u reimburse when you do NADAC minus. Conway insisted it is cost-based reimbursement rolled out across PSAOs and true independent pharmacies. He n that a lot of independent pharmacies are actually owned by wholesalers, or the P

are owned by wholesalers. This is true. The big three wholesalers are McKesson, Cardinal, and AmerisourceBergen. McKesson owns Health Mart pharmacies and Health Mart PSAO. Cardinal owns Elevate Provider Network. AmerisourceBerge owns Good Neighbor Pharmacy. So when Conway says independent pharmacies, are franchise operations owned by or affiliated with the wholesaler that supplies them.

Cuban agreed this is a great point. The big three wholesalers that dominate over of the business own these things called PSAOs that negotiate for roughly 5,000 pharmacies. The 90% figure is accurate. The 5,000 pharmacies number is low. He Mart alone has about 4,500 pharmacies, and there are multiple PSAOs. The total number of independent pharmacies in PSAOs is probably closer to 15,000-20,00 the point stands. So the wholesalers are negotiating the price for the pharmacies which creates its own set of agency problems.

This part of the debate reveals how acquisition cost opacity persists even when I claim to use cost-plus models. NADAC is a survey-based estimate, not actual inv cost. Generic compliance ratios mean pharmacies get chargebacks if they do not certain generic substitution thresholds, which affects their effective acquisition And the PSAO layer adds another negotiation where the wholesaler that sells dr pharmacies is also negotiating reimbursement rates on behalf of those same pharmacies. The conflicts are fractal. For investors and entrepreneurs, this matt because independent pharmacy networks are often positioned as the competitive alternative to vertically integrated PBM-owned mail order and specialty pharma But if independent pharmacies are buying from wholesalers that also negotiate t reimbursement through PSAOs, and those reimbursement rates are based on NA rather than actual acquisition cost, the independence is partly illusory.

Transparency, Cash Pricing, and Deductible Crediting

One of the most revealing exchanges came when they discussed why cash prices consistently lower than insured prices across the system. Cuban asked this ques

repeatedly and Conway kept deflecting. The phenomenon is real and well-documented. GoodRx, SingleCare, and other discount card programs routinely c prices 50-80% below insurance copays for the same drugs at the same pharmacie Healthcare Bluebook and other price transparency tools show similar patterns fo medical services. Cash prices for MRIs, lab tests, and procedures are often half c insurance-negotiated rates.

Conway tried to redirect to his broader point about hospitals and health systems being the main cost drivers compared to other countries. This is true but not responsive to Cuban's question. Hospital prices in the US are 2-3x higher than in other developed countries for the same procedures. But that does not explain wh cash prices are lower than insurance prices within the US market. Cuban kept pushing. Why is the cash price always lower? This is the question that breaks th of the insurance model. Insurance should create bargaining power that results in lower prices. If it consistently results in higher prices, something is very wrong.

Conway eventually engaged on the drug part, saying they should always look for lowest cost drug, and he is glad Cuban is doing what he is doing. OptumRx has p edge, which is their version similar to what Cost Plus does, and it has saved 275 million dollars. Price Edge is real. OptumRx announced it in 2023 as a program compares insurance prices against cash discount card prices and automatically g the patient whichever is lower. The 275 million in savings is unverifiable but pla given OptumRx's scale. But Cuban's question remains. Why do you need price ed when everything is already at net price and you are doing everything at the lowes possible cost? Why do you need all these other things?

If OptumRx has already negotiated the lowest net price and patients never pay m than net price, there should be no need for a program that compares against cash prices. The existence of Price Edge proves that insurance prices are sometimes h than cash prices even after all of OptumRx's negotiating. Conway said 90-plus pe of the time they are cheaper than Cost Plus 100% of the time. This claim is techn possible but highly suspect. Cost Plus publishes their prices. Anyone can compa Multiple independent analyses have found Cost Plus is cheaper than typical insu copays for the drugs they carry. Conway might be comparing OptumRx's net

acquisition cost against Cost Plus's retail price, which would make OptumRx loo cheaper but is not what patients actually pay.

Cuban said that is because of all the fees OptumRx adds elsewhere. Conway aske what fees. Cuban said he would pull out the contract and read where it says Opt will charge 5.5% of list price that they will not pass through, plus other fees and services including information technology to cover and track the rebates they cr This is referencing actual contract language. PBM contracts typically include administrative fees calculated as a percentage of ingredient cost, plus per-claim plus fees for various services. A 5.5% admin fee on list price is within the norma range. If a drug has a 1,000 dollar list price and a 400 dollar net price after rebat 5.5% fee would be 55 dollars, which is 13.75% of the net price. These fees are sep from rebates and not passed through.

This is the core of the value chain question. If a PBM negotiates a net price and through rebates, where does the PBM make money? The answer is administrativ spread pricing on generics, and various service charges. These are not necessaril unreasonable. PBMs do provide services including formulary management, prio authorization, claims processing, and clinical programs. The question is whethe fees are proportional to the value provided or whether they are a way to extract v that was supposedly passed through in rebates. Conway tried to agree with Cuba transparency and affordability but did not address the specific fee question.

The most policy-relevant part of this section came when a student asked about c pay and pricing transparency. Cuban asked Conway directly if he supports allow people to go out and get the best price for care and have it automatically count a their deductible. This is the cleanest policy intervention imaginable. Let patient care anywhere at any price, submit a receipt, and have it count against their deductible and out-of-pocket max the same as if they used an in-network provid Conway said yes, he thinks some of Cuban's ideas about counting purchases aga the deductible in both pharmacy and medical are very interesting. But he does n a payer anymore.

This is where the dodge happens. Conway ran Blue Cross Blue Shield of North Carolina from 2014-2019. He now runs Optum, which includes OptumRx and O Health but not UnitedHealthcare insurance. So he is technically correct that he not run a payer. But Optum and UnitedHealthcare are both part of UnitedHealt Group, and Conway has significant influence. If he ran a payer and could put thi and count it against the deductible, yes, he would do that. Cuban pointed out th Conway talks to the guy who does run the payer, meaning Andrew Witty, CEO o UnitedHealth Group, or whoever runs UnitedHealthcare specifically.

So would Conway tell him it is a great idea that everybody who goes out and buy cheaper drugs, whether from Cost Plus or an OptumRx pharmacy, should have i count against their deductible as long as they have a receipt? Conway said yes, is short answer. This is a significant concession if he follows through. The policy h been proposed in various states and at the federal level but has not been widely adopted. The insurance industry has opposed it because it reduces their control the network and makes it harder to steer patients to preferred providers. If Optu and UnitedHealthcare actually implemented this, it would be a major change. C asked if he can be invited to that meeting, which was both funny and a way to hc Conway accountable.

Conway tried to clarify the relationship, saying UnitedHealthcare pushes Optum hard for the best deal possible on all things, including OptumRx, just like every payer in the country. The dynamic is a little different than people might imagine is partially true. UnitedHealthcare does have an incentive to push Optum for go pricing because UnitedHealthcare's margins depend on medical costs. But the fa that both are owned by the same parent company creates shared incentives that exist in arms-length transactions. If Optum makes an extra billion in profit, that to UnitedHealth Group shareholders the same as if UnitedHealthcare made an e billion. Cuban noted that UnitedHealthcare is 75% of OptumRx's user base. Con said no, it depends on the business, but in pharmacy it is about 50% external and UnitedHealthcare.

This is an important factual dispute. UnitedHealthcare is the largest payer in th with about 50 million members. OptumRx serves about 100 million lives accordi

their disclosures. So 50% would be correct if all UnitedHealthcare members use OptumRx, which is roughly accurate. The 75% figure Cuban cited might be reve rather than lives, or might be outdated. Either way, the point is UnitedHealthca by far OptumRx's largest client, which creates alignment that does not exist wit external clients.

What This Reveals About Vertical Integration

Cuban eventually stated his policy preference directly. If he could change one th with all the power in DC, he would break up the big insurance companies. They cannot own PBMs, cannot own providers, cannot own their own technology. Ma them all independent companies. This is a coherent policy position. The argume that vertical integration creates conflicts of interest that cannot be managed thr internal controls or regulation. Better to structurally separate the functions and them compete. He pointed out that Optum owns 10 to 12% of physicians in this country.

Conway clarified they actually only employ about 10,000 to 12,000, despite peop citing 90,000. The rest are contracted. This is an important distinction that Con right to make. There are about 1 million physicians in the US. If Optum employ 90,000, that would be 9%, which would be an astonishing level of consolidation. actual number is 10,000-12,000 employed physicians, which is about 1%. But Op contracts with about 90,000 physicians through various value-based care arrangements, accountable care organizations, and other models. These physicia employed by medical groups or hospitals that have contracts with Optum.

The distinction matters for antitrust purposes because employed physicians can also work for competitors, while contracted physicians can have multiple arrangements. But Cuban's point is that from a patient and system perspective, distinction is not that meaningful. If a physician group is in a value-based care arrangement with Optum where Optum takes a percent of premium and the phy group shares in savings, the alignment is similar to employment even if the legal

relationship is different. The physician group is making clinical decisions that a
Optum's margin on the insurance side. This is the vertical integration question i
starkest form.

Optum includes health services delivery through Optum Health, pharmacy bene
and pharmacy services through OptumRx, and data and technology through
OptumInsight. UnitedHealthcare is the payer. When the same corporate parent
the insurance company, the PBM, the mail-order pharmacy, the specialty pharm
some physician practices, some surgical centers, and the data analytics platform,
transaction is both a market exchange and an internal transfer price. Conway's
defense of this structure is that it allows investment in prevention and compreh
solutions. He gave the example of value-based care models where taking a perce
premium from the payer allows investment in primary care, mental health care,
preventative care, and social determinants of health.

This argument has merit. Traditional fee-for-service Medicare pays for visits and
procedures but not for care coordination, phone calls, social workers, or other
interventions that prevent hospitalization. Value-based care arrangements that p
providers at risk for total cost of care create an incentive to invest in these upstr
interventions. Optum has demonstrated lower hospitalization rates and ED visit
their value-based care arrangements compared to fee-for-service, which is
documented in peer-reviewed studies. If you are managing total cost of care, you
intervene upstream before people get sick. The traditional fee-for-service model
cannot do this because there is no way to capture the value of avoided
hospitalizations.

The critique is that vertical integration creates the illusion of alignment while
actually just changing where the conflicts live. Instead of conflicts between paye
PBM, you have conflicts between OptumRx's negotiating position with manufac
and UnitedHealthcare's premium setting with employers. Instead of conflicts be
payer and provider, you have conflicts between what Optum Health physicians
recommend and what maximizes value for UnitedHealthcare's book of business.
conflicts do not disappear. They just get harder to see and harder to regulate. Th

also the fundamental question of whether the integration creates efficiencies tha benefit patients or whether it just creates market power that benefits shareholde

For investors and entrepreneurs, the question is whether vertical integration is a durable competitive advantage or a regulatory target. OptumRx is growing faste other PBMs, which Conway attributes to client satisfaction with transparency, c and affordability. The growth claim is verifiable. OptumRx has been gaining mar share while CVS Caremark has been losing share, based on publicly reported liv covered. Whether this is due to superior service or aggressive pricing that levera UnitedHealthcare's scale is debatable. Cuban's position is that this growth is happening despite structural problems that create information asymmetry and prevent real price competition.

The Real Cost Drivers Nobody Wants to Address

The one area where Cuban and Conway found common ground was hospitals. C pointed out that when you look at the US versus other countries, hospitals and h systems have been growing much more rapidly than any other country, and the p differential is very large. This is well-documented. The Health Care Cost Institu RAND Corporation, and multiple academic studies have found that hospital pri are the primary driver of healthcare cost growth in the US. Hospital prices incre 42% from 2007-2014 while physician prices increased 18% and drug prices incre 13%. Hospital consolidation has accelerated these trends, with hospital mergers leading to 20-40% price increases in affected markets.

Pharmaceuticals are also a primary cost driver. He told a story from his time at B Cross North Carolina negotiating with a hospital that wanted a 12% rate increas explained to their board that if the insurance company pays them 12% more, tha comes through in premiums. They said well, we do not want that, we just assum charge somebody in a different part of North Carolina. That is literally not how works. This anecdote rings true and illustrates the fundamental problem. Provic think of their negotiation with payers as a zero-sum game where they can extrac

revenue without affecting their own employees who buy insurance. But those employees are the premium payers, so provider price increases directly increase people pay for insurance.

The math for underlying costs drives premiums. Cuban asked why the cash pric always lower. Conway tried to stay on the macro point about hospitals and pharr prices being the main cost drivers. This is deflection but the macro point is corr you look at the US health system, there is amazing high-level care that is not distributed evenly in this country, and there is a cost problem. The major driver cost are hospitals and health systems and pharmacy, meaning pharmaceutical manufacturers and list prices and the whole structure of the system.

The current administration and the one before did a number of things around pharmaceutical pricing. This is true. The Trump administration issued multiple executive orders on drug pricing, created the Most Favored Nation model that w later rescinded, and allowed drug importation from Canada. The Biden administration passed the Inflation Reduction Act allowing Medicare to negotia prices on selected drugs, capped insulin at 35 dollars for Medicare beneficiaries, capped out-of-pocket costs at 2,000 dollars for Medicare Part D. These are real p changes though their impact will take years to measure.

There have been announcements about site-neutral payments in both administra It makes no sense that the exact same procedure gets 5x the reimbursement beca one day a hospital bought a physician practice. This is absolutely correct and on the clearest policy failures in healthcare. Medicare pays hospital outpatient departments substantially more than physician offices for the same services. A L office visit might reimburse 80 dollars in a physician office and 250 dollars in a hospital outpatient department. The policy was designed to help hospitals cover costs, but it has created a massive incentive for hospitals to buy physician practi and convert them to hospital outpatient departments without changing anything about how care is delivered. CMS has implemented partial site-neutral payment policies but they have been limited in scope and routinely scaled back after hosp lobbying.

This is the cleanest policy problem with the weakest political constituency for s it. Hospital prices in the US are multiples of hospital prices in other countries f same procedures. OECD data shows US hospital prices are 2-3x higher than oth developed countries even after adjusting for input costs and wages. Consolidatic given health systems market power in local markets. A 2020 study found that 90 metropolitan areas had highly concentrated hospital markets by antitrust standa The price discrimination is extraordinary, with insured prices many times highe cash prices for identical services.

The hospital price transparency rule requiring machine-readable price lists wen effect January 2021. Compliance has been extremely poor. A 2023 analysis found only 36% of hospitals were fully compliant, and enforcement has been minimal v maximum penalties of 300,000 dollars per year for large hospitals, which is trivi compared to their revenue. And site of service differentials mean the same proce costs five times more in a hospital outpatient department than in a physician off even after the hospital acquired the physician office.

But hospitals are large employers in every congressional district. They have sophisticated lobbying operations through the American Hospital Association a state hospital associations. They position themselves as essential community institutions, which many of them are, especially rural hospitals that are the only provider in their service area. And the price opacity means most patients do not the price until after the service is delivered, by which time they have limited rec The few policy interventions that have happened have been largely ignored with minimal enforcement.

Cuban's observation that cash prices are consistently lower than insured prices suggests the problem is not just that healthcare is expensive. The problem is tha insurance creates a price discrimination mechanism where the insured pay more the uninsured for the same services. This is backwards from how insurance shou work. Insurance should pool risk and negotiate lower prices through volume. In it appears to provide a mechanism for extracting higher prices from people who coverage. This phenomenon has been documented extensively. The Rand Corpor hospital price transparency study found that hospitals charge privately insured

patients 247% of Medicare rates on average, with significant variation. Some hos charge over 500% of Medicare. The uninsured who pay cash typically pay 100-15 Medicare.

What Entrepreneurs and Investors Should Actually Care About

This debate is valuable because it shows two intelligent operators arguing about specific mechanisms rather than abstract principles. The value for investors and entrepreneurs is in the details. When Conway says OptumRx has 100% rebate passthrough but it is being implemented over a multi-year contract cycle, that te you something about how long it takes to change an industry where contracts ha three to four year terms with NDAs. The implementation timeline is real and ma If a policy change is announced in 2024 but not fully implemented until 2027, th are three years where the old and new models coexist, creating arbitrage opportunities.

When Cuban challenges the claim by saying he cannot verify it because employe cannot compare contracts, that tells you something about information asymmetr structural feature rather than a bug. The NDA provisions in PBM contracts are incidental. They are designed to prevent price discovery and preserve pricing po When they argue about whether NADAC is true cost for independent pharmacie tells you something about how measurement problems create room for spread. T NADAC methodology has known limitations and lags, which create opportunitie PBMs to arbitrage the difference between actual acquisition cost and survey-bas benchmarks.

When they argue about whether OptumRx allows employers to work with Cost I and Cuban calls bullshit and offers to test the claim publicly, that tells you some about how different the claimed policy and the implemented reality might be. T between what companies say they do and what they actually do is where founder opportunities. When Conway says they employ 10,000 to 12,000 physicians but contract with 88,000, and Cuban dismisses this as a distinction without a differe

that tells you something about how value-based care contracts create alignment similar to employment. The legal structure matters for antitrust analysis but the economic alignment is what affects behavior.

The biggest takeaway for anyone building in this space is that the system is not optimized for what it claims to be optimized for. If the goal were to minimize pa out-of-pocket costs, deductible crediting for out-of-network purchases would be standard. It is not, which tells you the goal is actually to control network utilizat If the goal were transparency, PBM contracts would be public or at least compar across employers. They are not, which tells you opacity is valuable to someone in value chain. If the goal were to minimize total cost of care, cash prices would no consistently beat insurance prices. They do, which tells you insurance adds costs rather than reducing them in many cases.

This creates opportunities for startups. Cost Plus Drugs exists because there is a between net prices that PBMs negotiate and prices that patients actually pay. Th is real and documented. GoodRx exists because there is a gap between insurance prices and discount card prices. GoodRx generated 745 million in revenue in 202 arbitraging this difference. The direct primary care movement exists because the a gap between what primary care costs in a fee-for-service insurance model and it costs when paid directly. DPC practices charge 50-150 dollars per month for unlimited primary care, which is often cheaper than insurance copays for the sar services.

Every one of these businesses is exploiting a delta created by the complexity and misalignment in the traditional system. The risk is that these are all arbitrage opportunities rather than sustainable businesses. If PBMs actually implement 10 rebate passthrough and net pricing at point of sale, the gap Cost Plus exploits sh But the debate suggests this is not happening as completely as Conway claims. I deductible crediting becomes standard, the advantage of going outside the netw diminishes. But Conway's non-answer about actually implementing this suggest unlikely. If hospitals are forced to publish real prices and stick to them, the cash advantage disappears. But compliance with the existing transparency rule is 36% enforcement is the limiting factor not policy.

The debate suggests policy is unlikely to fix the underlying problems because th interests are too entrenched and the information asymmetry is too great. Conwa a quarter-trillion-dollar organization with 98% client renewal rates, though this number is likely inflated. Those clients are sophisticated employers and health p with consultants advising them. If they are not able to force better terms despite being repeat customers with options, what does that tell you about bargaining p The likely answer is that switching costs are high, alternatives are limited, and t complexity makes it hard to evaluate whether you are getting a good deal.

If OptumRx is genuinely passing through 100% of rebates and pricing at net dur deductible phases and paying independent pharmacies based on cost, why is the a market for Cuban's transparency crusade? The answer is probably that some o Conway says is true for some clients some of the time, and the complexity makes impossible for any individual employer to know whether they are getting the goo version of the contract or the less good version. The NDA provisions prevent employers from comparing notes. The multi-year implementation cycle means announced policy changes take years to affect all customers. And the bundling o PBM services with clinical programs and data analytics makes it hard to compar the drug pricing piece.

For entrepreneurs, the lesson is that complexity is a feature of the system, not a Every additional layer of intermediation creates information asymmetry and ren seeking opportunities. Every benefit design choice creates an opportunity for optimization that may or may not align with patient outcomes. Every vertical integration creates a principal-agent problem somewhere. The businesses that w the ones that either simplify dramatically, like Cost Plus publishing a price list a charging the same price to everyone, or the ones that embrace the complexity an become the integration layer, like Optum.

The policy lesson is harder. If you believe Cuban, the answer is breaking up vert integration to force transparency. There is historical precedent for this. AT&T w broken up in 1984 to separate long distance from local service. Standard Oil was broken up in 1911. The arguments for breaking up UnitedHealth Group into sep insurance, PBM, and provider companies have merit from a competition perspec

If you believe Conway, the answer is allowing vertical integration to enable inves in prevention and total cost of care management. There is also evidence for this. Kaiser Permanente has delivered better outcomes at lower costs through vertical integration for decades, though their model relies on employment rather than ju contracts.

Both are probably partly right. Vertical integration does allow longer-term investments that fee-for-service cannot support, and the Optum Health outcome appears legitimate. And vertical integration does create conflicts of interest that hard to manage and hard to regulate, and the pharmacy rebate data suggests significant value extraction. The actual path forward is probably neither breakin the big players nor allowing unlimited consolidation. It is more likely to be a me middle where some integration is allowed but certain practices are prohibited, w some transparency is required but full disclosure is not, where some standardiza is mandated but benefit design choices remain.

This creates continued opportunity for startups that can navigate the complexity better than incumbents or that can offer simplicity as a product. The debate betv Cuban and Conway is worth studying because it shows what arguments actually and what arguments fall flat. When Cuban asks specific questions about contrac terms and pricing mechanics, Conway has to either answer or deflect, and both responses are informative. When Conway talks about comprehensive solutions a clinical programs, Cuban can point out that those things cost money somewhere are not free, which is true and often forgotten in discussions about PBM value propositions.

Healthcare is a 4.5 trillion dollar industry in the US, roughly 18% of GDP. This i accurate based on CMS National Health Expenditure data. Pharmacy is about 60 billion of that, which includes retail prescription drugs at about 400 billion and specialty pharmacy at about 200 billion. The fact that two smart people can have substantive disagreement about whether a major PBM passes through rebates or prices drugs at net during deductible phases tells you something about how muc room there is for different business models and different interpretations of what actually happening.

The fact that Cuban can build a business around publishing a price list and Con can run a quarter-trillion-dollar services organization under the same regulatory regime tells you the system has enough complexity to support multiple strategie investors, the question is which strategies will still work in five years. If policy n toward breaking up vertical integration along the lines of various bills introduce Congress, the Optum model faces pressure and potentially forced divestitures. I policy moves toward mandating transparency with actual enforcement unlike th hospital price transparency rule, the information asymmetry that enables spread pricing disappears. If policy does nothing, which is the most likely scenario give congressional gridlock, the current dynamics persist and the arbitrage opportun remain.

Probably policy does something in the middle, which means the winners will be companies that can adapt to partial transparency and partial integration. The de did not resolve any of these questions. It did show what the actual disagreement beneath the talking points. That is valuable for anyone trying to build or invest i space, because understanding where the real friction points are tells you where t opportunities are.

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