Cuban’s healthcare provocation and why the devil lies in the implementation details

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Abstract

Mark Cuban's recent healthcare policy proposals target core dysfunction in drug pricing, insurance administration, and provider consolidation. This analysis exam nine specific recommendations ranging from Medicare rate anchoring for intercompany transfers to physician hospital ownership liberalization. Key tensi emerge between theoretical benefits (reduced administrative burden, pricing transparency, independent pharmacy survival) and implementation risks (regulat arbitrage, market exit, unintended consolidation acceleration). The wholesale ne pricing proposal represents the most technically complex intervention with high potential impact on pharmacy economics but also greatest measurement challen Contract standardization promises administrative savings but may ossify innova in payment models. Several proposals explicitly advantage Cuban's Cost Plus Dr business model, raising questions about self-interest versus public benefit alignı The package reflects sophisticated understanding of healthcare financial engine but underestimates state capacity requirements and second-order effects on mar structure.

The Full Manifesto

Cuban's LinkedIn post deserves to be read in full before dissection begins:

> For those legislators who are working on healthcare legislation right now, her some suggestions:
>
> 1) For intercompany medical charges, require them to be priced at Medicare r Ends gaming of MLRs
>
> 2) Require all insurance plans to apply any cash purchase against your deduct Let plan holders shop.
>
> 3) Require all pharmacy purchases by a plan holder to be charged at net price rebates. Right now YOU pay full retail price for branded meds in your deduc phase. You can thank your insurance company PBM for lying to you when the

they negotiate better prices. They obviously suck at their jobs if the best they do is get you retail price!

4) Require wholesale pharmacy pricing to be at net. This may seem like price controls. It's not. The wholesaler buys at retail, gets a prompt pay/data discou 5 pct from the manufacturer, then has the pharmacy buy from them at retail p minus a small discount. Which reimburses the wholesaler.

5) Wholesalers complain then don't make money on brands. Indie pharmacies crushed on brands. Manufactures don't make more money this way either. Wl Because they write HUGE rebate checks to the PBM!

Require pricing to be at net, and you improve cash flow and reduce reimburse risk for indie pharmacies. Patients can naturally pay lower cash prices for bra because pharmacies will pay much less.

Wholesalers can mark up their cost and make the same amount as they did be

The only loser in this? The PBMs, every one else gains

1) Create a moratorium on all acquisitions by ins carriers

2) If a medical provider of any kind, hospital, clinic, whatever, acquires anoth provider, they must retain the pricing (pre any price increases meant to game rule), for a period of 5 or 10 yrs, allowing only for cpi increases

3) Investigate the acquisitions of providers by pharmacy wholesalers.

4) Allow doctors to own hospitals

5) Standardize contracts by insurance carriers, by provider type. Every contra with every hospital, should have the same fill in the blanks with minimal vari This will cut administration costs dramatically

I can go on for days. This is a start

> Forgot the most important item. If brand pricing went to net via wholesalers, costplusdrugs could buy brands from them, mark them up only 15 pct, and cu price of EVERY SINGLE BRAND MEDICATION

The post reads like someone finally got fed up enough with healthcare's financia engineering to just say the quiet parts loud. Whether you think Cuban's a proph billionaire whose business model happens to benefit from these exact changes probably depends on how cynical you are about regulatory capture working in re What makes this interesting is these aren't hand-wavy "we should fix healthcare platitudes. These are surgical strikes at specific mechanisms that make drug pri and insurance administration unnecessarily complex.

Medicare Rate Anchoring and the MLR Shell Game

Cuban leads with intercompany transfer pricing, which is genuinely one of the s corners of health insurance finance. The MLR (medical loss ratio) requirement u ACA says insurers have to spend at least 80 or 85 percent of premium revenue or actual medical care depending on market segment. Seems straightforward until realize vertically integrated insurers can charge themselves whatever they want f services provided by their own subsidiaries.

UnitedHealth owns OptumRx, OptumHealth, Optum Insight, and a constellatio physician practices and surgery centers. When a United member fills a prescript an Optum pharmacy or sees an Optum physician, the charges that flow between entities count toward the MLR numerator. Set those intercompany prices high e and suddenly you're "spending" 85 percent on medical care while the economic stays in-house. It's transfer pricing 101, same thing multinationals do with Irish subsidiaries except the tax authority here is CMS and state insurance regulators are wildly outgunned.

Anchoring these transfers to Medicare rates would theoretically prevent the gam Medicare rates are public, relatively standardized, and already represent a bench that most of healthcare pricing orbits around. The appeal is obvious: take away t

ability to inflate costs through captive transactions and force actual market disc
on what counts as medical spending.

The problems show up in implementation. First, Medicare rates don't exist for everything. Medicare doesn't cover certain services, doesn't credential certain provider types, and has gaps in its fee schedules that would require regulatory g filling. Second, Medicare rates themselves are subject to political manipulation a geographic adjustment factors that create their own arbitrage opportunities. Th this only works if you can actually identify intercompany transactions, which re disclosure and enforcement infrastructure that doesn't currently exist at scale.

More fundamentally, if you force intercompany pricing to Medicare rates, you c huge incentive to simply stop using intercompany transactions. Spin out the subsidiaries with contractual relationships instead of ownership stakes. Use join ventures and management service organizations instead of direct subsidiaries. H PwC to design a corporate structure that technically complies while preserving t economic substance of the arrangement. The regulatory whack-a-mole becomes expensive for everyone involved.

The other issue is whether Medicare rates are actually the right benchmark. Me deliberately pays below market-clearing rates for many services, which is sustain because providers cost-shift to commercial payers. If you force commercial insu use Medicare rates for their own transactions, you're either going to see margin compression that drives exits from certain markets or you're going to see creativ redefinition of what constitutes an intercompany transaction. Neither outcome necessarily improves consumer welfare.

That said, the directional instinct is right. Letting vertically integrated insurers their own transfer prices with zero oversight creates obvious moral hazard. The question is whether Medicare rate anchoring is the best mechanism or whether y want something more like mark-to-market requirements where intercompany transactions have to be benchmarked against arm's length comparables. The latt harder to implement but probably more robust against gaming.

Cash Shopping and the Deductible Paradox

Proposal two sounds almost insultingly obvious until you realize it's not how mo insurance works today. If you're in your deductible phase and you find a cheaper price for a service or prescription, many plans won't credit that cash payment to your deductible. The economic logic from the insurer's perspective is they didn' "pay" for that service so why should it count toward the threshold where they st paying. From the consumer perspective this is insane. You're still spending mon healthcare, the deductible is supposed to measure your out-of-pocket exposure, the insurance company is actively discouraging you from finding lower prices.

The most egregious version of this happens in pharmacy. GoodRx and other disc cards often beat insurance copays, especially for generics during the deductible But if you use the discount card instead of running it through insurance, that purchase doesn't count toward your deductible. So you end up paying more mon aggregate because you're trying to avoid paying too much for individual fills. It's perfect example of how insurance design creates perverse incentives that increas total system costs.

Requiring plans to credit cash purchases toward deductibles would theoretically unleash consumer shopping behavior. If people could find lower prices and still credit toward their deductible, they'd have actual skin in the game for price sho This could create real market discipline on pricing, especially for common proce and medications where price variation is enormous.

The implementation challenges here are mostly around verification and fraud prevention. How does the insurer know you actually paid cash for a legitimate healthcare service versus submitting a receipt from your cousin's medical billing company? You need some kind of claim submission process for cash transaction which means standardized billing codes, provider verification, and adjudication workflows. That administrative overhead might eat up a lot of the theoretical sa from price shopping.

There's also a risk that this becomes a tool for insurers to push more services int cash-pay models. If people are going to get deductible credit anyway, why contra with certain providers at all? Just let members pay cash and submit receipts. Th might work fine for commodity services but creates access problems for comple where patients can't effectively shop and negotiate.

The other wildcard is whether this actually changes behavior at scale. Decades o research on consumer-directed health plans suggests most people don't price sh even when they have economic incentive to do so. Healthcare is credence good w quality is hard to assess, urgency often limits shopping time, and cognitive load navigating the system is already overwhelming. Adding deductible credit for cas purchases might help at the margins but probably doesn't transform market dyn unless coupled with much better price transparency tools.

Still, the directional logic is sound. If insurance is supposed to protect against financial risk, then spending your own money on healthcare should count toward risk threshold regardless of whether the insurer was involved in the transaction. question is whether the administrative cost of tracking and verifying cash purch exceeds the benefit from increased price competition.

Net Pricing at Point of Sale and the Rebate Illusion

This is where Cuban gets spicy with the PBMs. The rebate system in pharma is genuinely absurd. Manufacturers set high list prices, PBMs negotiate rebates th bring the net price way down, but patients pay based on the list price during the deductible phase. So if a drug has a $1,000 list price and a $400 rebate, the payer cost is $600 but the patient pays $1,000 out of pocket. The PBM pockets the spr least temporarily before some of it flows back to the plan sponsor through rebat sharing arrangements.

This system exists because PBMs get paid based on rebates they extract, which c incentive to prefer high-list-price drugs with big rebates over low-list-price dru with small rebates. It also means patients subsidize the overall system during th

deductible phase by paying inflated list prices while the payer gets the benefit of pricing over the full year.

Cuban's proposal to require net pricing at point of sale would mean patients pay post-rebate price even in the deductible phase. This is such an obviously consum friendly change that the fact it doesn't already happen tells you everything about whose interests the current system serves. The argument against it is usually that rebates are retrospective and variable, so the net price isn't knowable at point of That's technically true but also completely solvable with current technology. Real time benefit checks already happen at the pharmacy, adding rebate information that data flow is an implementation detail not a fundamental barrier.

The reason PBMs hate this is it exposes how little value they're actually adding. patients could see net prices at point of sale, it would become obvious that the P "negotiation" often results in higher patient costs than cash-pay alternatives. The entire value proposition of PBMs rests on information asymmetry between list p and net prices. Collapse that asymmetry and you have to justify your existence through actual operational efficiency rather than rebate capture.

The challenge with this proposal is defining what counts as a rebate. Manufactu provide rebates, discounts, fees, data payments, and various other forms of consideration to PBMs and plans. Some of it is explicitly tied to specific product some is portfolio-based, some is contingent on formulary placement or utilizatio management. Untangling this into a "net price" that can be calculated at point o requires standardization that doesn't currently exist.

There's also a question about what happens to rebates that are currently used to premiums for everyone. If rebates go directly to net pricing at point of sale, that transfer from healthy people who don't hit their deductible to sick people who d That might be good policy from an equity perspective but it will increase premiu which creates political backlash. The PBMs will argue they're currently using re to lower costs for everyone, and moving to net pricing will hurt the healthy majo to help the sick minority.

That argument is mostly bullshit because the current system is so opaque that n actually knows how much of rebate dollars flow to premium reduction versus PE margin versus plan sponsor profit. But it's politically potent bullshit that will definitely get deployed if this proposal gains traction.

The strongest version of this policy would couple net pricing at point of sale wit complete transparency on rebate flows. Show exactly how much the manufacture charges, how much the PBM extracts, how much goes to the plan sponsor, and h much stays with the PBM. That level of disclosure would make the current syste untenable and force real reform. But it also requires regulatory infrastructure th doesn't exist and political will to take on the PBM lobby, which is substantial.

Wholesale Net Pricing and Supply Chai Archaeology

This is the most technically complex piece of Cuban's proposal and also probabl highest leverage intervention. The current pharmaceutical supply chain involves manufacturers selling to wholesalers at WAC (wholesale acquisition cost, which basically list price), then providing various discounts and rebates after the fact. Wholesalers sell to pharmacies at WAC minus a small spread, then get reimburs through prompt pay discounts and other mechanisms. The pharmacy buys at nea WAC, submits a claim to the PBM, gets reimbursed at some rate that may or ma cover their acquisition cost, and the manufacturer writes huge rebate checks to PBM.

This Rube Goldberg machine exists for two reasons. First, it obscures actual pri different payers can get different effective rates without anyone knowing what a else is paying. Second, it allows PBMs to capture value through information asymmetry about what things "really" cost. If you're a pharmacy buying at WAC getting reimbursed at some algorithmic rate based on AWP (average wholesale p which is a made-up number) or MAC (maximum allowable cost, which the PBM unilaterally), you have no idea whether you're making or losing money on any giv prescription until after the claim adjudicates.

Cuban's proposal would eliminate this. Require manufacturers to sell to wholesa at net price after all discounts. Wholesalers mark up that net price by their marg and sell to pharmacies. Pharmacies know their actual acquisition cost and can se prices accordingly. The net price becomes visible throughout the chain, which m cash-pay customers and insurance reimbursement can both be based on transpa acquisition costs rather than fictional list prices.

The benefits are real. Independent pharmacies would have better cash flow beca they're not fronting money for ingredient costs that get reimbursed below acqui Wholesalers would have more predictable margins. Patients paying cash would g lower prices because pharmacies can price based on actual costs rather than WA And most importantly, the PBM rebate machine gets dismantled because there a more rebates to capture.

The implementation problems are substantial. First, defining "net price" is genu hard. Manufacturers provide value to PBMs through rebates, to plans through formulary fees, to wholesalers through data payments, and to pharmacies throug direct-and-indirect remuneration. Some of this is product-specific, some is portf based, some is contingent on performance metrics. Forcing all of this into a sing "net price" that wholesalers can use requires standardization that will take years implement and will inevitably leave gaps for gaming.

Second, moving to net pricing probably increases manufacturer prices overall. R now manufacturers can charge high WAC and then provide selective discounts t preferred payers. With net pricing, they lose that ability to price discriminate. T likely result is net prices end up somewhere in the middle, which means some pa (probably Medicaid and other public programs with statutory rebates) end up pa more while commercial payers pay less. That's a political land mine.

Third, the wholesalers might be telling the truth about not making money on br under the current system. If you force them to buy at net, they might just exit br distribution entirely and focus on generics where margins are better. That create supply chain disruption and access problems, especially for specialty drugs that require cold chain or other special handling.

Fourth, this proposal assumes the problem is PBM rebates, but that might be confusing symptom and cause. PBMs exist because pharmacy benefits are expen and complex to administer. Kill the rebate model and PBMs will find other ways extract value, probably through spread pricing on generics, administrative fees, vertical integration with mail-order pharmacies. You need comprehensive refor addresses the underlying market structure, not just one revenue stream.

That said, wholesale net pricing would be genuinely transformative if it could b implemented cleanly. The current system's opacity benefits exactly one set of stakeholders (PBMs and to some extent plans that share rebate revenue). Everyo else, from manufacturers to wholesalers to pharmacies to patients, would be bet with transparent pricing. The question is whether the political capital exists to f that change and whether the implementation can avoid creating new problems w than the ones it solves.

Acquisition Moratoria and Market Structure

Cuban wants to stop insurance carriers from acquiring anything. This is the nuc option on vertical integration, and it reflects genuine frustration with the UnitedHealth playbook of buying everything in sight until you're a fully integra healthcare conglomerate that's too big to fail and too complex to regulate.

The case for this is straightforward. Insurance carrier acquisitions consistently r competition, increase prices, and create conflicts of interest. When United buys physician practices, those practices start steering patients to Optum services. W Cigna buys a PBM, that PBM starts favoring Cigna-owned pharmacy chains. Wh Anthem buys surgery centers, those centers mysteriously become in-network wh competitors go out-of-network. Every one of these acquisitions gets approved by antitrust regulators with conditions that turn out to be toothless.

The moratorium would at least stop the bleeding while policymakers figure out coherent framework for vertical integration in healthcare. Right now we're in a v place where horizontal mergers (two insurers combining) get scrutiny but vertic

mergers (insurer buying provider, PBM, or tech company) mostly sail through. T asymmetry exists because antitrust law developed in eras when vertical integrati was assumed to be efficiency-enhancing. Modern industrial organization researc suggests vertical integration can be anticompetitive in markets with existing ma power, which healthcare obviously has.

The problems with a moratorium are mostly about collateral damage. Not all ver integration is bad. Some insurance carrier acquisitions genuinely improve care coordination or reduce administrative friction. Banning all acquisitions is a blur instrument that prevents both harmful and beneficial transactions. You'd ideally a framework that can distinguish between the two, but that requires regulatory capacity and sophistication that doesn't currently exist.

There's also a question about scope. Does this apply only to publicly traded carr also to regional Blues plans and Medicaid MCOs? Does it prevent acquisitions o companies and data analytics firms or just clinical providers and PBMs? The bro the moratorium, the more you risk stifling innovation. The narrower it is, the mo loopholes exist for structure-shopping.

The real issue is this proposal treats the symptom (acquisitions) rather than the disease (market power). If you want to prevent harmful vertical integration, you to either break up the existing giants or regulate them like utilities with rate-of- return constraints and structural separation requirements. A moratorium buys t but doesn't solve the underlying problem that these companies have enough mar power to extract rents regardless of their corporate structure.

Provider Consolidation Price Freezes

This proposal targets the other side of vertical integration: providers buying oth providers. The problem Cuban's addressing is real. When a health system acquir independent physician practice or community hospital, prices tend to spike. The acquired entity gets reclassified from independent to hospital-owned, which mea the same exact services now get reimbursed at higher rates through facility fees hospital pricing.

A five or ten year price freeze would prevent that arbitrage. If you acquire a prov you have to keep their prices where they were (adjusted for inflation) for long en that the acquisition has to be justified through actual operational efficiencies ra than pricing power. This forces health systems to make integration actually worl instead of just extracting rents through rate reclassification.

The implementation challenges are significant. First, defining "pricing" in healt is nearly impossible. There's no single price, there's a whole schedule of rates negotiated with different payers, with different terms, modifiers, and carve-outs you freeze all of them? Just the commercial rates? What about contracts that exp during the freeze period, can they be renegotiated?

Second, this creates massive adverse selection in what gets acquired. Health syst will only buy practices and facilities they think they can make profitable under f pricing. That's probably going to be well-run, efficient operations with good pay mixes. The struggling practices that might actually benefit from integration sup won't get acquired because the economics don't work under a price freeze. You accelerating the death of independent practice rather than preserving it.

Third, price freezes don't prevent other forms of value extraction. The health sy can't raise prices but they can change utilization, shift patients to higher-margin services, reclassify service codes, or extract value through management fees and service contracts. The price freeze might constrain one margin lever while openi others.

The strongest version of this policy would couple price freezes with utilization monitoring and total cost of care accountability. Don't just freeze prices, require acquired entities maintain or reduce total spending per patient. That's much har game and actually aligns with value-based care objectives. But it also requires da infrastructure and regulatory oversight that most states don't have.

The Wholesaler-Provider Integration Question

Cuban flags pharmacy wholesaler acquisition of providers for investigation with specifying what the concern is. This is probably referring to McKesson, Cardina Health, and AmerisourceBergen buying oncology practices, specialty pharmacie other clinical operations.

The anticompetitive concern is theoretically about vertical integration creating captive markets. If a wholesaler owns pharmacies, they can require those pharm to buy exclusively from their wholesale division even if better prices exist elsewh If they own oncology practices, they can require buy-and-bill chemotherapy dru come through their distribution channel even if the practice could get better de through group purchasing organizations.

The reality is this integration is probably less harmful than insurance carrier ve integration because wholesalers have less market power. There are three major d wholesalers, and while that's not perfect competition, it's better than the insura market where most local markets have two or three dominant carriers. Physician pharmacies owned by wholesalers can still negotiate and switch suppliers more than they can switch insurance networks.

That said, investigating these acquisitions makes sense. The pharmaceutical sup chain is already opaque enough without adding more vertical integration. If wholesalers are using provider ownership to foreclose competition or extract re through transfer pricing, that deserves scrutiny. But this probably shouldn't be priority relative to insurance carrier integration or PBM conflicts of interest.

Physician Hospital Ownership Revival

This one's interesting because it's actually deregulatory. The Affordable Care Ac banned physician-owned hospitals from expanding or opening new facilities, ostensibly because they were cherry-picking profitable patients and procedures leaving expensive care to community hospitals. That policy has been controversi since implementation, with physicians arguing they were being shut out of hosp ownership to protect incumbent systems from competition.

Cuban wants to lift the ban, and the argument for doing so is pretty straightforv
Physician-owned hospitals tend to be more efficient, have better patient satisfac
scores, and focus on specialized procedures where physician governance makes s
Banning them doesn't stop cherry-picking, it just ensures that incumbent hospit
maintain oligopoly pricing without competitive pressure.

The case against physician hospital ownership is mostly about conflicts of intere
Physicians who own the facility have incentive to over-utilize services, order
unnecessary procedures, and self-refer in ways that increase revenue. Those con
exist in any fee-for-service environment, but ownership makes them more acute.

The empirical evidence is actually pretty mixed. Some studies show physician-ov
hospitals cherry-pick, others show they provide equivalent or better care at lowe
cost. The reality is probably that some physician-owned hospitals are great and s
are terrible, same as community hospitals. The blanket ban prevents experiment
with governance models that might actually improve efficiency.

Lifting the ban would probably increase competition in certain specialty proced
markets, which could reduce prices and improve quality. It would also create ne
opportunities for physicians frustrated with hospital employment models. The r
you get proliferation of single-specialty facilities that fragment care and leave
complex patients with nowhere to go. The right policy is probably to lift the ban
requiring certificate of need review and community benefit obligations, but that
requires state-level implementation that will vary wildly.

Contract Standardization Fantasy

This proposal sounds great until you think about it for thirty seconds. Standardi
insurance carrier contracts by provider type, fill-in-the-blank templates, minima
variance. Cut administrative costs dramatically by not having every hospital neg
bespoke contracts with every payer.

The appeal is obvious. Healthcare administration is wildly expensive, with estim
suggesting twenty-five to thirty percent of spending goes to billing, coding,

credentialing, and contract management. A lot of that is pure waste from having different contracts with different terms for the same services. Standardization co eliminate huge amounts of overhead.

The problem is contracts are how markets work. Different providers have differe capabilities, serve different populations, and face different cost structures. Diffe payers have different network strategies, utilization management approaches, an population health models. Contracts are where those differences get negotiated. Standardizing contracts means either forcing everyone to accept generic terms t work poorly for their specific situation or creating so many carve-outs and speci cases that you've recreated bespoke contracts with extra steps.

There's also a fundamental tension between standardization and innovation. A l interesting payment models (bundled payments, risk-sharing arrangements, qua bonuses, care coordination fees) require contractual innovation. If you lock ever into standardized templates, you prevent experimentation with new approaches. might be worth it if administrative savings are large enough, but you're definitel trading off flexibility for efficiency.

The version of this that might work is standardizing the structure and process o contracting rather than the substance. Require contracts to be in plain language prohibit certain abusive terms (gag clauses, retroactive denial provisions, unilate rate changes), and mandate transparency on key terms. That would reduce administrative burden without eliminating the ability to negotiate terms that re local market conditions.

Cost Plus Drugs as Policy Beneficiary

Cuban's addendum about Cost Plus Drugs is where the quiet part becomes loud wholesale pricing went to net, his company could buy brands from wholesalers, them up fifteen percent, and undercut current retail pricing dramatically. This i obviously true, and it's also obviously why he's advocating for these policies.

That doesn't make the policies wrong. Lots of good policy happens because some with resources and influence has aligned incentives. Cost Plus has demonstrated transparent markup pricing can work for generics, and there's no reason the mo couldn't extend to brands if the supply chain changed. The current system wher brands are mostly available only through PBM-controlled channels at opaque pr worse for consumers than Cuban's model would be.

The question is whether these policies would actually enable Cost Plus to compe brands or whether incumbents would find ways to preserve their moats. PBMs c require exclusivity from manufacturers as a condition of formulary placement. Manufacturers could refuse to sell to wholesalers who then supply transparent retailers. Payers could steer patients away from Cost Plus through higher copays prior authorization requirements.

In other words, supply chain reform is necessary but not sufficient for disruptio also need protections against foreclosure tactics, anti-steering rules, and most fa nation clauses that prevent manufacturers from offering better terms to PBM-controlled channels than to independent pharmacies. Cuban's not wrong about wholesale net pricing enabling his business model, but he's probably underestim how hard incumbents will fight to prevent that model from scaling.

What Gets Lost in Translation

The biggest issue with Cuban's proposals isn't that they're wrong, it's that they assume policy implementation is straightforward. Every one of these ideas sounc simple in a LinkedIn post but becomes a nightmare of regulatory definition, ind pushback, and unintended consequences when you try to actually write rules.

Take wholesale net pricing. To implement that, you need to define net price, spe what counts as a rebate versus a discount versus a fee, determine timing for whe prices get set, establish enforcement mechanisms for violations, create safe harb for legitimate business practices, and probably set up a whole new regulatory apparatus at FDA or FTC to oversee compliance. That's years of rulemaking, thousands of public comments, intensive lobbying, court challenges, and eventu

implementation through guidance documents that create as many questions as t
answer.

Or contract standardization. Who writes the standard contracts? Do they vary b
or are they federal? How often can they be updated? What's the process for getti
exceptions for innovative payment models? How do you enforce compliance whe
both parties have incentive to deviate from standard terms? The administrative
machinery required to make this work at scale is enormous.

This doesn't mean the proposals are bad. It means policy is hard, and good polic
really hard, and transformative policy that threatens trillion-dollar industries is
almost impossibly hard. Cuban's got the diagnosis right, but the treatment plan
requires state capacity and political will that may not exist.

The other thing these proposals don't address is the fundamental structure of
healthcare financing. Most of these interventions are trying to make the current
system less dysfunctional, but they don't question whether employer-sponsored
insurance with fee-for-service payment and third-party intermediaries is the rig
model. Maybe the better answer is moving to direct primary care, capitated payr
Medicare for All, or some other approach that doesn't require intricate regulatic
PBM rebates and transfer pricing.

But that's a bigger conversation than Cuban's trying to have. He's offering practi
interventions that could happen through regulation or legislation without blowi
the whole system. Whether that's ambitious enough probably depends on how
pessimistic you are about fixing healthcare through incremental reform. The
optimistic case is these policies chip away at the most egregious rent extraction
create space for better models to emerge. The pessimistic case is they're rearran
deck chairs while the fundamental problems of misaligned incentives and marke
concentration get worse.

Either way, Cuban's putting ideas on the table that most people in positions to d
something about healthcare are too cautious or too captured to propose. That's
valuable even if implementation would be a mess. Healthcare policy has suffered

lack of imagination about what's politically possible, and having someone with resources and platform pushing the Overton window is probably net positive. Ju don't expect any of this to happen quickly or cleanly, and don't be surprised whe final implemented version looks nothing like the LinkedIn post.

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