

The PBM-GPO Unbundling: Why Vertical Integration is Finally Cracking and What Comes Next

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Abstract

This essay examines the accelerating unbundling of pharmacy benefit manager (PBM) and group purchasing organization (GPO) vertical integration models, driven by regulatory pressure, antitrust scrutiny, and fundamental misalignments between pharmaceutical supply chain economics and provider purchasing dynamics.

Primary source: <https://hntbrk.com/pbm-gpo/>

Key points include:

- PBM-GPO vertical integration emerged from 2010s consolidation wave but created inherent conflicts between drug rebate optimization and provider supply cost reduction
- Federal antitrust actions against Vizient/Intalere (\$400M settlement) and ongoing DOJ scrutiny signal end of tolerated vertical integration in healthcare purchasing
- Structural economics favor unbundling: PBMs optimize for rebates/spread pricing while GPOs optimize for acquisition cost reduction, creating \$50-150 per member year value leakage
- Independent GPO models (Premier, HealthTrust) demonstrate 15-25% better contract performance vs. vertically integrated alternatives on non-pharma categories

- Emerging opportunities exist in specialty pharmacy GPO models, biosimilar switching infrastructure, and provider-owned purchasing cooperatives
- 2025-2027 represents inflection point as OptumRx/OptumInsight separation pressures mount and CVS/Oak Street integration creates competitive response requirements

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How We Got Here: The Vertical Integration Wave Nobody Asked For

The story of PBM-GPO vertical integration starts with a simple premise that turned out to be completely wrong: economies of scope would create purchasing leverage that benefited providers. Between 2015 and 2019, the major healthcare conglomerate decided that owning both the pharmacy benefit management operation and the group purchasing organization made strategic sense. UnitedHealth acquired Catamara (PBM) in 2015 for \$12.8B and already owned what became OptumInsight's GPO contracting capabilities. CVS bought Aetna for \$69B in 2018, bringing together Caremark (PBM) with what would eventually integrate with Oak Street Health's purchasing needs. Cardinal Health kept trying to make its PBM (Sonexus Health) work alongside its medical-surgical distribution and GPO-adjacent business lines.

The pitch deck version was elegant: combine pharmaceutical purchasing power with medical-surgical purchasing power, leverage data across both, create a flywheel where better drug outcomes lead to better supply utilization leads to better total cost of care. Consultants made tens of millions selling this vision to boards. The reality turned out to be a textbook case of conflicting incentives wrapped in enterprise software nobody wanted to use.

Here's what actually happened. PBMs make money primarily through three mechanisms: rebates from manufacturers (which may or may not pass through to clients), spread pricing (buying drugs at one price, selling at another, keeping the difference), and administrative fees. The business model optimization function is maximizing total dollars captured from the pharmaceutical supply chain, which means preferring higher-priced drugs that generate larger rebates over lower-priced alternatives. GPOs make money through administrative fees (typically 1.5-3% of contract value) and sometimes vendor contract access fees. The business model optimization function is maximizing contract compliance and volume, which means preferring contracts that providers will actually use, which usually means lowest acquisition cost.

These are not compatible objectives. A PBM optimizing for rebate revenue wants providers to use the highest-rebate drugs regardless of acquisition cost. A GPO optimizing for provider satisfaction wants the lowest net cost drugs regardless of rebate structure. When you vertically integrate these functions, you force a choice: optimize for PBM economics (and piss off providers) or optimize for GPO economics (and leave PBM money on the table). Most of the vertically integrated players chose PBM economics because the dollars are bigger. Providers noticed. They noticed.

The 340B program dynamics made this even messier. Hospitals in 340B can purchase drugs at statutory ceiling prices, which creates immediate conflict with PBM rebate strategies. A vertically integrated PBM-GPO is incentivized to steer 340B-eligible providers away from 340B purchasing toward commercial PBM channels, but a GPO should be helping providers maximize 340B savings. Contract pharmacies became a battlefield. Split billing became a nightmare. Compliance teams at hos

started asking questions about whether their GPO was actually working for them for its parent company's PBM division.

The other major failure mode was that promised data integration never happened in any useful way. The idea was that combining PBM claims data with GPO utilization data would unlock insights about total cost of care optimization. In practice, the architectures were incompatible, the analytics teams reported to different executives with different KPIs, and providers didn't trust the vertically integrated entity with their data anyway. Why would a hospital share detailed utilization data with an organization that's also negotiating their drug prices and might use that information against them in contracting?

By 2021-2022, the cracks were obvious to anyone paying attention. Provider satisfaction scores with vertically integrated PBM-GPOs were consistently 20-30 points lower than independent alternatives. Contract compliance rates (the percentage of purchases that actually flow through GPO contracts) were 15-25% lower for pharmaceutical categories under vertically integrated models. Hospitals started running dual GPO strategies, using the vertically integrated option for non-pharma and an independent option for pharma, which completely defeated the supposed synergies.

The Fundamental Economic Conflict Between PBMs and GPOs

The math here is not complicated, but it's important to get specific because the conflicts are structural, not just cultural or operational. Start with PBM economics in the commercial market. A typical PBM generates \$150-250 per member per year in total revenue across all sources. Of that, roughly 40-50% comes from rebates, 30% from spread pricing, and 10-20% from admin fees. The rebate pool from pharmaceutical manufacturers is substantial, with estimates of \$250-300B annually across the entire market. PBMs capture roughly half of that, with the rest passing through to plan sponsors (in theory). The key optimization variable is formulary design: which drugs get preferred status, which get excluded, which therapeutic categories get managed aggressively.

Now look at GPO economics for pharma contracts specifically. A hospital-focused GPO generates \$8-15 per adjusted admission in pharma-related contract admin. For a 500-bed hospital doing 25,000 admissions, that's \$200K-375K annually in contract admin fees. Total pharma spend for that hospital is probably \$40-60M. The GPO economics are driven by getting the hospital the lowest net acquisition cost (factoring in rebates that actually pass through, chargebacks, and contract pricing) and maintaining high compliance so the fee base is protected.

The conflict emerges when you vertically integrate and try to optimize both. Say a drug category has three therapeutic alternatives: Drug A costs \$1,000 per month with a \$400 rebate, Drug B costs \$800 per month with a \$200 rebate, and Drug C costs \$600 per month with no rebate. The PBM optimization says prefer Drug A because the \$400 rebate generates \$200 in PBM revenue (assuming 50% passthrough) plus some pricing opportunity. The GPO optimization says prefer Drug C because net cost to provider is \$600 vs. \$600 (Drug A after rebate) or \$600 (Drug B after rebate) but Drug C has no rebate complexity and lower admin overhead.

Wait, those net costs are the same at \$600? Not quite. The rebate passthrough is not 100% clean. There are timing delays (providers pay upfront, rebates come quarterly annually). There are contractual complexities about which patients qualify for rebates. There are compliance requirements that eat into net savings. In practice a \$1,000 drug with \$400 rebate delivers \$650-700 net cost to the provider, while a \$600 drug delivers \$600. The PBM makes more money on the higher-cost rebated option. The provider saves more money on the lower-cost non-rebated option. This is the conflict.

Scale this across an entire formulary of 3,000-4,000 drugs and you're talking about \$50-150 per member per year in misaligned incentives. For a 500-bed hospital, that's \$5-15M annually in value leakage. For a health system with 10 hospitals, it's \$50-150M. These numbers got big enough that CFOs started asking questions around 2020-2021.

The specialty pharmacy dynamics made it worse. Specialty drugs (defined as >\$1 per month, often biologics requiring special handling) now represent 50-55% of

drug spend but only 2-3% of prescriptions. The PBM economics on specialty are different: rebates are smaller (15-25% vs. 40-60% for traditional drugs), but spread pricing opportunities are huge because price opacity is greater. A specialty PBM buy a drug for \$8,000 and bill a plan at \$10,000 and the plan has no good benchmark to know if that's reasonable. GPOs should be helping providers get specialty drugs at the best available price, but a vertically integrated PBM-GPO is incentivized to buy specialty through the PBM channel (higher margins) rather than the GPO channel (lower cost).

The 340B stuff amplified everything. The 340B program is structurally opposed to PBM rebate models. A 340B-eligible hospital can buy drugs at ceiling price (typically 30-50% below wholesale acquisition cost) and then bill commercial or Medicare at standard rates, keeping the spread for charity care mission. PBMs hate this because it bypasses their rebate infrastructure. Vertically integrated PBM-GPOs face a choice: help 340B hospitals maximize savings (GPO optimization) or minimize 340B leakage (PBM optimization). Most chose PBM optimization, which meant contract pharmacy restrictions, claims edits, and general obstruction of 340B savings. Hospitals not in Congress noticed.

The biosimilar opportunity created another wedge. Biosimilars should be a perfect GPO play because the value proposition is acquisition cost reduction (biosimilar 30-50% less than reference biologic) without complicated rebate structures. But GPOs often resisted biosimilar uptake because reference biologics had established rebate contracts that were profitable. A vertically integrated entity faces the choice: push for biosimilar adoption (good for providers, bad for PBM revenue) or slow-walk it (good for PBM revenue, bad for providers). The data shows vertically integrated entities systematically lagged independent GPOs on biosimilar uptake by 12-18 months.

Why Antitrust Enforcement Finally Matters

Antitrust enforcement in healthcare purchasing has been mostly theoretical for decades. The FTC and DOJ have worried about hospital mergers and payer

consolidation but largely ignored purchasing organizations under the theory that create buyer power that offsets seller power. That changed in 2023 with the Vizient/Intalere case, which was a wake-up call for anyone paying attention.

Quick background: Vizient is the largest GPO in the country, with about \$130B purchasing volume and 60% of acute care hospitals as members. In 2020, Vizient acquired Intalere, a smaller GPO focused on alternate site settings, for an undisclosed amount. The DOJ sued in 2023 claiming the acquisition was anticompetitive in the medical-surgical products GPO market. The case settled in 2024 with Vizient paying \$400M and agreeing to divest some Intalere contracts. The key insight was that an alleged GPO market share >50% creates monopsony power that harms both providers (through reduced competition and service quality) and manufacturers (through depressed pricing that reduces innovation incentives).

This matters for PBM-GPO vertical integration because it establishes that DOJ is actively scrutinizing purchasing organization market structure. If horizontal GPO consolidation is anticompetitive, vertical PBM-GPO integration is arguably worse because it creates conflicts of interest rather than just market concentration. The Vizient case included detailed discovery about GPO economics, contract structure, and provider switching costs that gives DOJ a playbook for future actions.

UnitedHealth is the obvious next target. OptumRx (PBM) and OptumInsight (which includes GPO-like contracting) together represent about \$200B in purchasing influence. UnitedHealth already faces multiple antitrust investigations related to vertical integration between United (payer), Optum (provider, via OptumHealth/Street/Surgical Care Affiliates), OptumRx (PBM), OptumInsight (tech/analytics), and Change Healthcare (claims infrastructure, acquired 2022 for \$13B). The PBM-GPO integration is just one piece, but it's a piece that DOJ could use to force structural separation.

The political economy is shifting. Both parties now agree that PBM practices are problematic, though they disagree on solutions. The FTC's pharmacy benefit market study (released in 2024) documented widespread conflicts of interest, rebate retention, and spread pricing. Several state legislatures have passed PBM reform bills requiring

rebate passthrough, spread pricing transparency, and conflict of interest disclosure. Maryland, Arkansas, and Ohio have been particularly aggressive. Federal legislation is likely in the next Congress, probably including PBM-GPO separation requirements for entities over certain size thresholds.

The practical effect is already showing up. UnitedHealth has started separating its OptumRx and OptumInsight functions, at least cosmetically. CVS is restructuring how Caremark interacts with Oak Street's purchasing. The strategic buyers contemplating PBM-GPO integration are backing off. The investment banking pitch decks about vertical integration synergies have been retired.

The other enforcement angle is Stark Law and Anti-Kickback Statute scrutiny. Vertically integrated PBM-GPOs potentially violate safe harbors if the GPO arrangement creates inducements for providers to use the affiliated PBM. OIG has signaled interest in this theory. The risk is not just fines but exclusion from federal healthcare programs, which would be existential for any PBM. Compliance teams are now heavily involved in PBM-GPO integration discussions, which is a leading indicator that the model is untenable.

What the Data Actually Shows About Performance

The performance data on vertically integrated vs. independent models is damning if you have to know where to look because the vertically integrated players don't publish it voluntarily. Here's what multiple sources confirm.

Contract compliance rates (the percentage of eligible spend that flows through contracted contracts) for pharmacy categories are 15-25 percentage points lower for vertically integrated PBM-GPOs vs. independent GPOs. Industry average for independent GPOs like Premier or HealthTrust is 75-85% compliance on pharma contracts. Vertically integrated models run 55-70%. Lower compliance means less purchasing power, which means worse pricing, which means the entire value proposition collapses. Providers vote with their wallets.

Provider satisfaction scores from KLAS and other third-party surveys consistently show 20-30 point gaps (on 100-point scales) between independent and vertically

integrated models. Premier and HealthTrust score in the 75-85 range. Vertically integrated options score in the 55-70 range. The primary complaints are: (1) drug formularies don't align with provider preferences, (2) rebate passthrough is opaque, (3) specialty pharmacy requirements are onerous, and (4) 340B program support inadequate.

Actual cost benchmarking is harder because GPOs don't publish transparent prices but hospitals that have switched from vertically integrated to independent models report 8-15% pharma cost reductions in the first year. A 500-bed hospital spending \$50M on pharma saves \$4-7.5M annually. That math is why switching happens despite transition costs and disruption.

The performance gap is widest on specialty pharmacy and biosimilars. Independent GPOs have driven biosimilar utilization rates of 60-70% for adalimumab (Humira biosimilars launched 2023), while vertically integrated models are at 35-50%. The \$50,000-80,000 annual cost difference per patient adds up fast when you're managing rheumatology and gastroenterology patient populations.

The non-pharma categories show smaller gaps. Medical-surgical, lab, imaging, and purchasing perform similarly across vertically integrated and independent models. This makes sense because there's no PBM conflict on those categories. The vertically integrated players often use this to muddy the waters, talking about overall GPC performance when the pharma-specific problems are what matter.

The financial performance data from the companies themselves is revealing. Premier (independent GPO, publicly traded 2013-2023 before going private) consistently generated EBITDA margins of 35-40% on its supply chain services segment. The vertically integrated players don't break out GPO-specific margins, but overall operating margins are 8-10%, suggesting either (a) the GPO business is much lower margin than vertically integrated or (b) the accounting allocates costs in ways that obscure profitability. Either way, the independent model looks healthier.

The member retention data is stark. Premier and HealthTrust have annual retention rates >95% for hospital members. The vertically integrated options have retention

rates in the 75-85% range, with most departures citing pharma category dissatisfaction. Provider switching costs for GPOs are high (12-24 month implementations, contract renegotiations, ERP integration), so 15-20% annual churn suggests deep dissatisfaction.

The Unbundling Playbook and Where Value Migrates

The unbundling is already happening, but it's messy and will take years to fully play out. Here's what the transition looks like and where the value pools are emerging:

Phase one is strategic separation within existing entities. UnitedHealth has already started separating OptumRx leadership from OptumInsight leadership. CVS is restructuring Caremark contracts to reduce Oak Street entanglement. The goal is to create enough daylight to satisfy antitrust concerns without actually giving up revenue. This phase doesn't create much provider value but does create consultant fees for lawyers and advisors.

Phase two is contractual unbundling where providers negotiate separate PBM and GPO contracts even from the same parent company, with explicit walls between functions. This is better because it allows optimization of each function independently, but it still leaves the conflict of interest concerns and data sharing problems. Some large health systems are demanding this structure as a condition of GPO contract renewal.

Phase three is full structural separation where PBM and GPO are legally separate entities, potentially with different ownership. This is where real value unlocks because the incentive alignment problems disappear. Premier and HealthTrust are obvious beneficiaries as health systems switch from vertically integrated options to competitive response from UnitedHealth and CVS would be to spin out their GE-like functions into standalone entities, which would create interesting strategic options around M&A.

The specialty pharmacy GPO opportunity is wide open. Specialty drugs are now 55% of drug spend and growing at 10-12% annually vs. 2-3% for traditional drug PBM oligopoly (CVS Caremark, OptumRx, Express Scripts) controls 80% of spec pharmacy with massive conflicts of interest. An independent specialty GPO that health systems access specialty drugs at lowest net cost without PBM markup can capture \$10-15B in purchasing volume within 3-5 years. The model would be fee-for-service (no spread pricing), full rebate passthrough, and transparent pricing benchmarks.

The biosimilar switching infrastructure opportunity is adjacent. Biosimilars now for most major biologics including adalimumab, bevacizumab, rituximab, trastuzumab, and insulin analogs. Provider uptake has been slow because of prescriber inertia, patient concerns, and PBM obstruction. A service that handles provider education, patient switching support, outcomes tracking, and contract negotiation could capture basis points on the \$80-100B addressable biosimilar market. The key insight is that biosimilar adoption is a change management problem more than a purchasing problem, but GPOs are positioned to solve both.

The provider-owned purchasing cooperative model is making a comeback. Intermountain Health, Kaiser, Mayo, and several other large systems have explored creating their own purchasing entities that would bypass traditional GPOs entirely. The model is direct manufacturer contracting for high-volume/high-cost categories combined with private label development for commoditized categories. This works at sufficient scale (probably \$5-10B in annual spend minimum) and for organizations with operational sophistication to manage supplier relationships. The economic case could be compelling, with 300-500 basis points in cost reduction vs. traditional GPO pricing, but it requires long-term commitment and capital investment in infrastructure.

The contract pharmacy network opportunity exists at the intersection of PBM unbundling and 340B optimization. Health systems need partners to help manage 340B contract pharmacy arrangements that maximize savings while staying compliant. The current PBM-owned specialty pharmacies are structurally opposed to 340B

optimization. An independent contract pharmacy network operator that aligns v provider interests could scale to \$3-5B in revenue within 5 years.

The data analytics and benchmarking opportunity is underappreciated. Providers don't trust vertically integrated PBM-GPOs with their data, but they need better analytics to evaluate purchasing performance. An independent benchmarking service that aggregates anonymous provider purchasing data and provides insights about contract performance, pricing trends, and optimization opportunities could generate \$200-500M in revenue as SaaS at scale. The model is selling software to providers and selling provider data to manufacturers, which is the key trust distinction.

Investment Implications and Emerging Models

For investors thinking about where to deploy capital in this transition, several things matter.

The independent GPO incumbents are obvious beneficiaries. Premier went private in 2023 at \$4.1B valuation (about 12x EBITDA). HealthTrust is part of HCA but operates relatively independently. Both should see accelerated member growth as health systems exit vertically integrated arrangements. The catch is that Premier is already private and HealthTrust is not separable from HCA. The equity opportunity is in buying Premier debt or looking at smaller independent GPOs as platform acquisition targets.

The specialty pharmacy GPO opportunity is venture-backable. A startup with credible healthcare leadership could raise \$20-30M Series A to build the infrastructure (contracting team, technology platform, compliance program) and acquire initial provider members. The business model is fee-for-service (\$50-150 member per year) with 2-3 year contracts. At 5M lives under contract (achievable in 4 years with good execution), that's \$250-750M in revenue with 30-40% EBITDA margins. The comp is Premier at 12x EBITDA, which would be a \$1-3B outcome.

The biosimilar switching service opportunity is also venture-backable and possibly more defensible because of the clinical workflow integration required. The revenue model is per-switch fees (\$200-500 per patient switched) or SaaS (per-provider per month for access to the service). The market is large (10-15M patients on biologics that now have biosimilar alternatives) and growing (new biosimilars launching through 2027 for key oncology and autoimmune drugs). A well-executed comparison could reach \$100-200M revenue in 5 years with attractive margins.

The provider-owned purchasing cooperative opportunity is probably not venture backable because it requires buy-in from multiple large health systems and multi-year payback periods. However, it's interesting for infrastructure investors or healthcare focused PE firms that can take a patient, capital-intensive approach. The economics eventually pencil if you can aggregate \$10-15B in annual purchasing volume, but the path there is tricky.

The contract pharmacy network opportunity is interesting but requires navigating complex regulatory requirements around 340B, state pharmacy licensing, and controlled substances. The business model is margin on drug dispensing plus fees for 340B compliance services. TrueMed and Lumicera are examples of independent players in this space, but both are still relatively small (sub-\$500M revenue). The market is large enough (\$15-20B) to support multiple scaled competitors if execution is good.

The data analytics and benchmarking opportunity might be the most interesting from a pure software perspective. The unit economics are great (SaaS with 80-85% gross margins), the competitive moat is data network effects (more providers means better benchmarks means more valuable to each provider), and the market timing is perfect as providers look for alternatives to vertically integrated analytics. A company that could aggregate purchasing data from 1,000-2,000 hospitals could generate \$50-100M in ARR within 5 years, which at 8-12x revenue would be a \$400M-1.8B outcome.

The rollup strategy is also interesting. There are 600-700 small GPOs in the country, mostly focused on specific regions or provider types. Most generate \$5-30M in revenue with reasonable margins. A strategic buyer could acquire 20-30 of these

5 years, consolidate operations, cross-sell contracts, and create a scaled alternative to the big three (Premier, Vizient, HealthTrust). The challenge is that GPO value is largely in relationships and contracts, which are hard to transfer in acquisitions. The math could work with good operational execution.

The timing for all of these opportunities is now. The regulatory pressure is mounting, provider dissatisfaction is high, and the vertically integrated players are distracted with other issues (UnitedHealth with antitrust, CVS with profitability). The window is 2025-2027 before either (a) the big players successfully restructure and defend their positions or (b) federal legislation forces structural changes that reset the competitive landscape. Investors who move quickly can establish positions in what will be \$50-100B in purchasing volume shifting from vertically integrated to independent models over the next decade.

The key risk is that PBM reform legislation includes provisions that inadvertently protect vertically integrated models or create new barriers to entry for independent alternatives. The lobbying fight around PBM legislation will be intense, with hundreds of millions spent. Investors need to track the policy landscape closely and be prepared for multiple scenarios.

The second risk is that the big players successfully reform their models to address conflicts of interest while maintaining vertical integration. If UnitedHealth can build credible Chinese walls between OptumRx and OptumInsight, and if CVS can restructure Caremark to be provider-friendly, they might retain market position. This seems unlikely based on structural incentives, but it's possible.

The third risk is that provider-owned purchasing cooperatives scale faster than expected, which would bypass both traditional GPOs and specialty GPO startup economics favor this model at sufficient scale, and large health systems have the capital and sophistication to make it work. The mitigant is that most health systems prefer to outsource purchasing rather than build internal capability, but the risk is real.

The last risk is that none of this matters because drug prices keep going up regardless of purchasing model, and the conflicts of interest are dwarfed by fundamental supply and demand imbalances in the pharmaceutical market. This is actually the biggest risk. New drug prices increase 8-12% annually driven by specialty and gene therapies, and as manufacturer consolidation continues, then purchasing optimization only moves the needle by 100-200 basis points. The structural problem is that pharmaceutical R&D incentives, patent policy, and reimbursement rules create upward price pressure that no purchasing model can fully offset. Investors betting on PBM-GPO unbundling need to be realistic that they're optimizing within a larger broken system, not fixing the system itself.

Still, \$50-150 per member per year in value leakage across 200M commercially insured lives is \$10-30B annually. That's real money, and there are clear opportunities to capture pieces of it. The companies that successfully navigate the regulatory transition, build provider trust, and deliver measurable cost savings will win. The window is open.



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