The surprising announcement last week was that Blue Shield of California is dropping its pharmacy benefit manager, or PBM, CVS Health’s Caremark. *The Wall Street Journal* reported: “Instead, Blue Shield, a nonprofit health plan with about 4.8 million members, will work with a selection of companies that each perform a designated function. Amazon will offer at-home drug delivery. Cuban said Mark Cuban Cost Plus Drug Company will provide access to low-cost medications, including through retail pharmacies. Another company, Abarca, will process drug claims.”

What should one make of this? Any health insurer has to manage its pharmaceutical spending. It is an essential part of running a profitable enterprise. This function could be done in-house as one division of the health insurer. Or, the insurer could contract with a third party to manage the drug spend – a PBM. So, one way to think of the Blue Shield move is that it is bringing in-house the management of its drug spending and hiring contractors to perform specific functions.

Will it work? Eakinomics has no idea. According to the *Journal*: “Blue Shield said its plan, which it hopes to fully launch in 2025 after a limited rollout next year, could save the company about $500 million annually, or about 10% to 15% of what the insurer currently spends on drugs.” Sounds like a lot of money. But it also reported: “CVS filed a statement with the Securities and Exchange Commission late Thursday saying the Blue Shield shift will have an immaterial impact on the company’s financial results.”

At present, the PBM industry is being investigated by the Federal Trade Commission, scrutinized by Congress, and is potentially the target of numerous pieces of legislation. If the Blue Shield reorganization is successful, it could present a market-based, innovative disruption that shakes up the PBMs. That is far preferable to having Washington micromanage the industry. It is a development that merits close scrutiny.