



# How Health Plans Can Take Back Control of Pharmacy Spend

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# The Role of Data Visibility in Cost-Effective Pharmacy Benefit Pricing

Despite years of reform, the U.S. pharmacy pricing system remains one of the most complex and opaque components of healthcare. The rise of vertically integrated Pharmacy Benefit Managers (PBMs), evolving revenue models, changing governmental regulations, and limited access to granular claims data have created a landscape where health plans struggle to make informed, strategic decisions.

## THE PROBLEM:

### Complexity Without Clarity

Pharmacy costs continue to climb, but many health plans lack the data and infrastructure required to make informed, strategic decisions about pharmacy spend. Pricing misalignments, hidden fees, and contract structures that restrict data access have turned pharmacy benefits into a black box, impeding Payers' ability to act and contributing to rising costs.

- Pharmacy pricing is increasingly opaque
- PBM's interests are misaligned with plan goals
- Health plans often don't have access to the data required to manage spend effectively
- Payers face barriers to evaluating performance or validating value

## The Purpose of This eBook

This guide provides clarity on the complex systems influencing pharmacy benefit costs and offers actionable insights for Payers to address these challenges.

In the pages ahead, we'll:

- Define what true transparency in pharmacy pricing looks like
- Breakdown how the current system conceals costs and impedes performance
- Explore the practical, data-driven steps health plans can take to regain control of their pharmacy spend

Transparency is the great enabler: with the right data and the right partners, Payers can drive smarter decisions, support members, and improve financial outcomes.



## PART 1

# The State of the Market and the Need for Transparency

### **Fragmented System, Opaque Costs**

The pharmacy benefit market has shifted from a relatively linear system into a tangled web of vertically integrated entities, layered incentives, and increasingly opaque pricing structures. Vertical integration is so pervasive it now spans the entire drug supply chain, from rebate aggregation to specialty pharmacy and data monetization.

### **The Rise of Hidden Fees**

As PBMs have expanded their control, their profit strategies have shifted. No longer primarily reliant on fees collected from the Payers or retention of manufacturer rebates, they now generate revenue through rebate Group Purchasing Organization (GPO) fees and specialty pharmacy, models that are far less transparent to Payers.

Nephron Research (2023) found that in 2012, 55% of revenue earned by PBMs was derived from the retention of rebates and “spread” pricing (reimbursing the retail pharmacy less than the Payer is billed).

And according to Drug Channels, the majority of the PBMs’ revenue in 2024 was from the PBM-affiliated specialty pharmacy and fees retained by the PBM-affiliated rebate GPO.

Since the PBM doesn’t directly own the Specialty Pharmacy or the rebate GPO, the Payers are not privy to the amount of revenue retained by these entities for their claims.

### **Contracting Entities Add Another Layer**

PBM-owned companies have contributed to the rise of this revenue model. In 2022 alone, they introduced approximately \$1.7 billion in new fees (Nephron Research, p. 11). These fees are commonly tied to the Wholesale Acquisition Cost (WAC), a pricing metric that is often disconnected from actual net cost. According to Nephron (p. 13), 67% of manufacturers say WAC-based fees disincentivize price reductions, making it harder for health plans to capture savings even when drug prices decrease.



In 2012, 55% of revenue earned by PBMs was derived from the retention of rebates and “spread” pricing.

(Source: Nephron Research, 2023)

This evolving market structure leaves plan sponsors with limited visibility and even fewer tools to evaluate how their pharmacy benefit design aligns with cost and value goals.

Many are cut off from the data required to verify costs, assess outcomes, or compare vendors on a level playing field. The result is a system where health plans are increasingly expected to manage spend without a clear view of how money is moving or who’s retaining it.

As PBMs continue to evolve into multi-entity revenue engines, the data needed to manage spend and drive smarter decisions is increasingly complex for the Payer organizations who contract and pay for their services.

#### KEY TAKEAWAYS

- PBMs now manage claims, rebates, dispensing, and data while increasingly generating revenue through GPO fees and specialty pharmacy
- Contracting entities add complexity and opacity to the pharmacy benefit market
- Vertical integration keeps pharmacy revenue within a small group of entities offers/provides less transparency to Payers



## PART 2

# What Transparent Pricing Actually Requires

## Defining True Transparency in Pharmacy Benefits

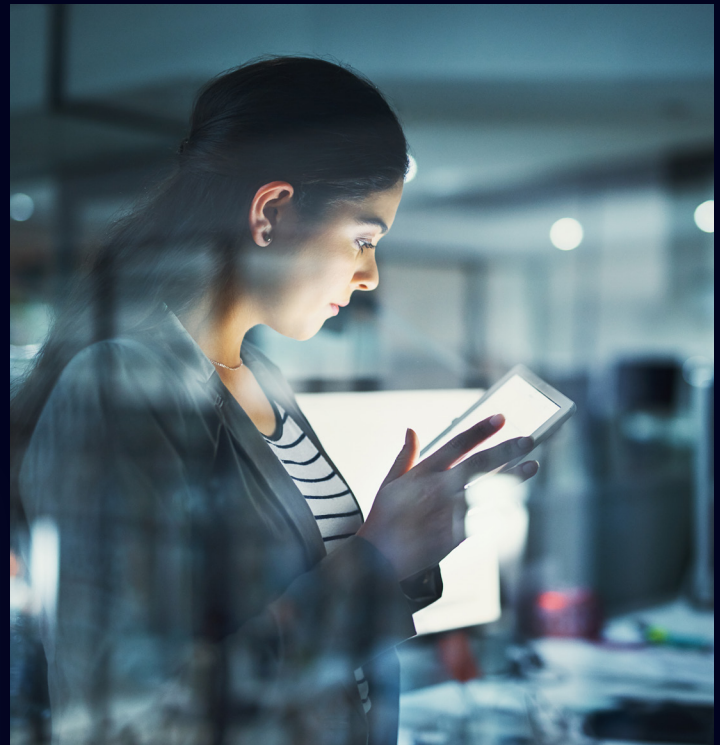
In a system dominated by complexity, true transparency is more than a buzzword. It's a requirement for health plans seeking to make informed, data-backed decisions. While some PBM arrangements may claim to be “transparent,” the reality is that most still operate under contract structures and data-sharing limitations that leave Payers in the dark.

### What Transparency Should Actually Mean

True transparency in pharmacy benefits goes well beyond “pass-through” pricing. It requires:

- Claims-level data, including rebate payment details linked to National Drug Codes (NDCs)
- Invoice-level clarity – specifically, visibility into the amounts paid to pharmacies versus what was billed to the plan
- Full disclosure of revenue retained by PBMs, their affiliated companies, and specialty pharmacies

Without this level of granularity, health plans are left without the information needed to compare vendors, evaluate formulary decisions, or understand how member experiences are being shaped by behind-the-scenes incentives. Even self-insured plans often struggle to gain access to their own claims data, and when they do, it is often only part of the picture.



## Barriers That Obscure the Full Picture

There are systemic barriers that prevent most health plans from accessing the data they need. Common challenges include:

- Restricted contract terms that limit what data a health plan can request or audit
- Undisclosed revenue streams, including fees retained by PBM-affiliated entities or affiliated pharmacies
- Definitions of “transparency” that amount to partial visibility – often excluding critical claims or invoice-level data
- If the Payer does have access to all of the data, there is difficulty pulling the disparate data together in a useful format



These structural limits are not new. For years, PBM business models have faced criticism for their lack of transparency regarding how rebates are distributed, negotiated, and retained.

The Inflation Reduction Act of 2022, [as explained by KFF](#), introduced important drug pricing reforms, including new requirements around Medicare drug negotiations and rebate penalties for price increases above inflation. However, the law does not directly

address the opaque rebate arrangements between PBMs, manufacturers, and Payers in the commercial market.

This underscores a persistent gap: even as federal policy targets drug pricing more broadly, commercial PBM practices are constantly changing that allow the practices to remain largely shielded from scrutiny, with limited visibility into how much is being paid, to whom, and why.

In 2015, researchers noted that the lack of transparency around rebates limits the ability of plan sponsors to evaluate costs. A decade on, that concern remains relevant and largely unresolved.

This lack of transparency isn't just a technical issue. It has real financial and operational consequences for health plans and the members they serve.

### PART 3

## The Systemic Impact of Transparency – Or Lack Thereof

### Nontransparent Models vs. Transparent Approaches

The lack of transparency in the pharmacy benefit space doesn't just create administrative challenges. It has material consequences for access, cost, and patient experience. From health plans to individual members, the ripple effects of opaque PBM structures are felt across the healthcare ecosystem.

When discussing transparency, it's important to distinguish between the contract itself and the way the PBM operates:



#### Transparent contract:

Provides visibility into how the PBM generates revenue but doesn't extend to how its affiliates or related businesses make money.



#### Transparent PBM:

Extends transparency across the broader business model, offering clarity not only into contracts but also into how the organization functions as a whole.



## The Hidden Costs of Opaque PBM Models

Opaque pricing practices such as undisclosed rebates, spread pricing, and layered fee structures can distort plan economics, limit member affordability, and reduce the effectiveness of pharmacy benefit strategies.

These revenue models often separate cost from value. For example, rebates negotiated by PBMs are typically not tied to clinical outcomes or net cost to the Payer. Spread pricing, which is where the PBM charges the Payer more than it reimburses the pharmacy, can lead to inflated costs without visibility into where the margin is captured.

Meanwhile, contracting entities owned or affiliated with PBMs continue to introduce new fees that are difficult for plans to validate. Nephron Research (p. 10) found that PBM contracting entities fees grew from near zero to \$759 million in just four years. These fees often sit between manufacturers, Payers, and patients, compounding complexity without improving access, cost, or quality.

## The Systemic Impact is Clear:

- Misaligned incentives drive decision-making that prioritizes margin over member value
- Data opacity makes it nearly impossible for Payers to assess performance or course-correct
- Fee layering erodes trust and complicates efforts to design sustainable, transparent pharmacy networks

At the pharmacy level, PBMs may reimburse affiliated pharmacies at higher rates than unaffiliated ones, distorting cost comparisons and undercutting competition. This concern has drawn scrutiny from federal regulators; the FTC is investigating pricing disparities between affiliated and unaffiliated pharmacies. (Source: Drug Channels, 2025)

The impact of these opaque practices extends directly to members and Payers.



### FOR MEMBERS: Access Barriers and Price Confusion

Opaque rebate structures mean members may pay the full drug price at the point-of-sale, despite the existence of negotiated rebates. These rebates rarely flow back to the member.

Members may also face restricted pharmacy access and higher out-of-pocket costs due to exclusive PBM networks that prioritize affiliated pharmacies or mail-order services. These restrictions can limit member choice and degrade the care experience.



### FOR PAYERS: Data Gaps and Limited Oversight

Payers face their own set of challenges when working with nontransparent PBMs. Without rebate data at the claim level, health plans are unable to evaluate the true cost of a drug or determine whether a particular network or formulary strategy delivers value.

In many cases, Payers lack a comprehensive view of their total pharmacy spend. They also lack the data needed to evaluate performance or adjust strategy, making the common industry mantra “trust but verify” an empty promise without the right data.



## What Transparent PBMs Do Differently

Transparent PBMs offer a fundamentally different approach. Rather than limiting access to information, they enable health plans to see and understand the full picture.

A transparent PBM model includes:

- **Rebate-level data at the claim level**
- **Full disclosure of fees and revenue** retained across all entities, including specialty pharmacies, contracting entities, and aggregators
- **Invoice-level reporting** that can be independently verified
- **Payer input on network design**, with fair reimbursement to local pharmacies and access to lower cost pharmacy options

This level of transparency supports Payers in making more informed decisions and to better align benefit design with financial and clinical goals.

## The Benefits of True Transparency

For health plans, transparent pricing is both a compliance goal and a strategic advantage. With access to real data, Payers can:

- Compare **actual net drug costs** across PBMs and cost-containment strategies
- Evaluate the **value of formulary decisions**, both financially and clinically
- Ensure **per-member-per-month (PMPM) guarantees** are being met
- Gain a **holistic understanding of total pharmacy spend**

(Source: Employers Deserve Better)

## For members, the benefits are just as clear:



**More accurate pricing** at the point-of-sale



**Improved access** to in-network pharmacies without being pushed into mail-order models



**Greater confidence** that plan dollars are being used to improve outcomes

Transparent PBM models offer both control and clarity. They equip health plans with the insights needed to act by supporting smarter strategies, better cost containment, and a stronger alignment between spend and outcomes.



## PART 4

# Market Momentum and the Future of Transparency

### A Shift in Power and in Expectations

Transparency in pharmacy pricing is no longer a fringe demand. A growing coalition of stakeholders that include state regulators, employers, advocacy groups, and disruptive market entrants are pushing for a system that is more open and fundamentally better aligned with outcomes.

The call for change is clear: it reflects growing dissatisfaction with a system that feels increasingly unmanageable and out of sync with Payer and member needs. Rigid contracts limit the ability of health plans to pivot when costs spike or member needs shift. And as PBMs evolve into multi-entity revenue engines, Payers are left with diminishing insight into how pharmacy dollars are spent and who ultimately benefits.

This erosion of trust is compounded by member frustration. Patients are facing rising drug costs, reduced pharmacy choice, and benefit designs that prioritize financial structures over accessible, affordable care. The downstream impact of opaque pricing is being felt at the pharmacy counter every day.



### Legislative Pressure Builds

Across the country, state lawmakers are taking direct aim at opaque PBM structures. A few examples: Arkansas legislation has banned PBMs from owning pharmacies, which is a direct response to concerns about anticompetitive behavior and misaligned incentives. Iowa just passed a law to reform PBM practices with provisions designed to curb spread pricing, mandate full rebate pass-through, establish transparent reimbursement standards, and restrict patient steering. California recently enacted a law aimed at curbing 'abusive' PBM practices by banning spread pricing, requiring PBMs to be licensed, and prohibiting PBMs from negotiating exclusive deals with manufacturers.

Meanwhile, federal scrutiny is ramping up. The FTC is actively investigating pricing disparities between PBM-affiliated and unaffiliated pharmacies, a move that could influence future regulation and reshape industry norms.

### In Focus: Regulation Rising

- Arkansas: Ban on PBM pharmacy ownership
- FTC: Ongoing investigation into PBM pricing practices  
(Sources: SME Transcript; Drug Channels, 2025)
- Iowa: Passed a law reforming PBM practices
- California: Signed in a law to curtail "abusive" PBM practices



## Health Plans Face Rising Pressure to Drive Accountability

Change is coming from the ground up and health plans are feeling the impact firsthand. Members are increasingly aware of rising drug costs, limited pharmacy access, and unclear benefit structures. This shift is placing new pressure on health plans to ensure their PBM partnerships are built on flexibility, measurable value, and transparency.

At the same time, scrutiny over plan oversight is increasing. Recent litigation involving benefit fiduciaries, such as lawsuits filed against Johnson & Johnson and Wells Fargo alleging mismanagement of prescription drug benefits, has raised the stakes around data access, contracting practices, and transparency expectations. For health plans, this moment demands more than minimal compliance. It requires a commitment to strategies that are clearly aligned with financial performance and long-term sustainability.

## Transparency is a Strategic Imperative

Pharmacy benefit pricing has become one of the most significant blind spots in healthcare spending. Hidden fees, layered contracting structures, and limited access to claims-level data continue to drive cost inflation, misaligned incentives, and a lack of visibility into true drug spend.

For health plans, the consequences are measurable. Opaque PBM arrangements create real financial risk and limit a plan's ability to optimize performance, manage member outcomes, or deliver on fiduciary responsibilities.

End-to-end transparent pricing is a must for a competitive strategy. With the right partners and data infrastructure in place, health plans can:

- Reduce waste
- Protect member access
- Align spend with outcomes
- Continuously improve financial performance





PART 5

# Transparency that Drives Results

## A Better Model Is Within Reach

Transparent PBM models provide health plans with:

- Greater control over their pharmacy strategies
- Better alignment between incentives, costs, and outcomes
- Insights that support accountable, data-driven decision-making

Newfound transparency then turns guesswork into strategy and supports Payers to lead future strategic decisions with greater precision.



## How MacroHealth Supports Transparency in Action

MacroHealth enables health plans to operationalize transparency by turning real-world claims data into actionable intelligence. Through our MacroHealth Intelligent Exchange™ (MiX) platform, we deliver the infrastructure necessary to evaluate and optimize pharmacy claims.

Key capabilities include:

- **Granular visibility** into medical and pharmacy claims – level data, allowing plans to understand what they’re paying for at every stage
- **Evaluation and comparison of network partners** based on claims, pricing, and utilization performance data
- Flexible tools that allow plans to **adapt and refine PBM configurations** as business needs evolve
- **A centralized platform** to support continuous performance evaluation, market trend analysis, and informed vendor comparisons

With the MiX platform, plans can build a clearer, more responsive pharmacy strategy – one that adapts as market conditions, member needs, or vendor relationships evolve.

MacroHealth gives you the transparency you need to make strategic decisions.

### The MiX Platform in Action



Up to 40% reduction in pharmaceutical spend



Control over 50% of your pharmacy spend with a Specialty Rx solution



10+ PBM Health Market Partners



## Ready to realign your pharmacy strategy?

Connect with MacroHealth to learn how our platform supports transparency, unlocks savings, and powers holistic benefit optimization.

