When Payers Know the Price of Everything

US payers are increasingly leveraging new, publicly visible price benchmarks in commercial negotiations.

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> *"In the US, we don't talk about a single price point for drugs. Whether it's MFP, direct-to-patient cash-pay, or political theater, commercial drives the pharmacy budget, and we wouldn't be doing our jobs if we didn't negotiate with the leverage we have."*
>
> — LARGE REGIONAL MCO

EXECUTIVE SUMMARY

Payers Increasingly Treat Public Prices as Leverage

Complexity in the US healthcare system is not new, and neither is the debate over the rising cost of care. From a payer standpoint, drug prices remain a central focus. What has changed is the tone: Pharmacy directors are increasingly discussing cross-channel price disparities not as background noise, but as leverage points in the ongoing effort to control drug spend.

In a market where payers can essentially "know the price of everything," as Oscar Wilde might put it, are they beginning to see the value of nothing, focusing solely on the lowest net cost rather than on differentiated value?

In conversations with US payers about this environment, the benchmark cited most often is the maximum fair price (MFP) established under the Inflation Reduction Act, which sets a negotiated ceiling price for select high-cost Medicare medications. But other publicly visible price benchmarks are increasingly in play as well, including direct-to-patient (DTP) cash offers available through brand websites, novel agreements such as Eli Lilly's "Employer Direct" program, and speculation about the potential impact of the Most-Favored-Nation (MFN) executive order.

For manufacturers, the market access (and ultimately financial) risk is not that any single channel-specific price point will force renegotiation of an existing contract. It is that a growing number of these benchmarks become commercially actionable at the same time, particularly in crowded therapeutic categories. Many public prices are not directly comparable across products, indications, books of business, channels, or benefit designs, but visibility itself invites comparison, and that comparison can translate into direct financial impact over time.

> *"Each new market price gives us a talking point. If patients are getting treatments for a certain price, I'm going to go and get that same price. Whether it's Part D, commercial, or purchased on an app, why should that impact the price required for our patients?"*
>
> — LARGE REGIONAL MCO

What payers are telling us

THREE THEMES FROM OUR RESEARCH:

1
MFP spillover is real but selective.

It is strongest when a public price sits meaningfully below current net cost and the payer has a real way to act on it.

2
DTP pricing is now a payer-facing decision.

It creates both a visible price anchor and legitimate concerns about fragmented care, safety, and data.

3
Payer economics are diverging.

MFN and PBM reform will not produce one uniform market response, which means contracting strategy must be account-specific.

1 MFP: A Commercial Benchmark, Not a Commercial Mandate

MFP is a Medicare price, not a statutory commercial one. It becomes leverage when the public price is materially below current net cost, payers see clinically comparable products, and they have a way to reward discounts, whether through preferred status, pathway placement, or volume.

An integrated purchaser described extending a major new discount on a selected oncology asset into commercial contracting, while another payer saw little disruption in classes where deep discounts already existed. This suggests the headline discount matters less than the specific considerations at the asset, category, and account level.

> *"We would expect that level of pricing not only for Part D, but for similar or related products, and we are using it to negotiate better contracting on the commercial side."*
>
> — PHARMACY DIRECTOR, REGIONAL MCO

2 Direct-to-Patient Pricing Is Reshaping Negotiation

GLP-1s are the clearest case of DTP pricing changing the game, driven by the collision of high demand, coverage gaps, and public cash prices. Payers are using those prices to ask why comparable discounts cannot support insured access. One pharmacy director raised a separate, and legitimate, concern: Direct channels can fragment medication records, safety checks, adherence data, and prescribing workflows.

As one plan executive put it, "Direct-to-patient access can be attractive, but it de-aggregates the whole system." The growing number of public prices, including the Medicare GLP-1 Bridge and current manufacturer programs, makes the comparison more visible, but not automatically relevant. Dose, form, eligibility, duration, service scope, government-pricing exposure, data integration, and volume commitments were all raised as factors that determine whether a cash price is truly comparable.

> *"If you can offer the product for $100 or $200 direct pay, why are we not seeing 50% or 60% rebates for broader formulary access?"*
>
> — PHARMACY DIRECTOR, REGIONAL MCO

3 MFN and PBM Reform: Political Theater, Real Reference Points

Ask a payer about MFN and the likely answer is some version of "political theater." One pharmacy director called it "a big black hole" that plans cannot yet operationalize. The administration has announced multiple voluntary MFN agreements, and CMS has proposed international-price-linked Medicaid models.[1] Whether or not it can be operationalized in the near term, each proposal adds another visible reference point to the pile, even without a consistent mechanism behind it.

The same dynamic is playing out in PBM reform. One payer expects rebates to "reappear under a different label." Another put it more bluntly: "It's just about the net. I don't care how I get there." Recent fee-based PBM announcements and regulatory settlements reinforce a market that is segmenting rather than converging. A rebate-dependent account, a true-net-cost plan, and an integrated purchaser will not respond to the same benchmark the same way, which is exactly why a single national playbook will not hold up account by account.

> *"MFN is still a big black hole… we cannot implement policies or strategies when we do not know what we are looking at."*
>
> — PHARMACY DIRECTOR, REGIONAL MCO

A FRAMEWORK FOR MANUFACTURERS

When Does a Public Price Become Commercial Leverage?

Not every visible price becomes a negotiating point. Across our conversations, two factors consistently determined whether a benchmark actually moved a contract: how credible the benchmark is, and how able the payer is to act on it.

	LOWER BENCHMARK CREDIBILITY	HIGHER BENCHMARK CREDIBILITY
HIGHER PAYER ACTIONABILITY	PAYER PRESSURE, BUT DEFENSIBLE	HIGHEST RISK OF DIRECT CONTRACTING & ACCESS PRESSURE
LOWER PAYER ACTIONABILITY	LOW NEAR-TERM IMPACT	NARRATIVE PRESSURE; RISK CAN BUILD OVER TIME

BENCHMARK CREDIBILITY

- Public or easily discoverable
- Same product, condition, or a credible substitute
- Meaningful gap versus current net cost

PAYER ACTIONABILITY

- Clinically defensible utilization management, pathway, or preference
- Ability to shift volume or align physicians
- Account economics reward true-net-cost action

IMPLICATIONS

What Manufacturers Should Consider Now

In this era of rising price transparency, where nearly every available price point for a product is discoverable, payers are gaining incremental leverage in contracting. That does not mean every benchmark warrants a reaction, but it does mean exposure needs to be actively managed rather than addressed account by account as it arises. Four actions stood out across our conversations:

1

Map exposure at three levels:
Score the selected asset, relevant competitors, and account archetypes to identify where a public price is most likely to become a negotiating point.

2

Pre-build the comparability answer:
Prepare the evidence base and objection handlers for channel, dose, service, and eligibility differences that support the value story before the question is asked.

3

Match the contract to the payer model:
Treat accounts separately depending on rebate dependency versus a broader net-cost focus or an integrated-purchaser structure.

4

Govern every public price:
Require Market Access sign-off before DTP, low-WAC, MFN-linked, or employer-specific pricing is launched, so that no public move creates an unexpected benchmark and payer negotiation tool.

THE BOTTOM LINE

The issue is no longer whether public price benchmarks matter. It is which payer accounts can convert them into a negotiation tool, and whether the manufacturer is prepared before the demand is made.

Conclusion

Price transparency is not going away, and the payer pressure it creates will only increase. In this environment, mapping category risk, understanding each account's specific drivers, and methodically governing pricing decisions are essential to protecting product profitability. Equally important is a defensible evidence package for value, paired with account-specific strategy, to answer the payer holding a price list and asking, "Why not us, too?"

ABOUT THIS RESEARCH

This white paper is based on Beghou's research with pharmacy directors across large national and regional health plans, PBMs, and integrated delivery networks, conducted in the second quarter of 2026.

ABOUT THE AUTHORS

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REFERENCES

1. Kaiser Family Foundation, *"A Look at the Generous Model and Factors That Could Impact Medicaid Drug Costs."*

For a deeper discussion of how these dynamics apply to a specific asset or account portfolio, please contact the Beghou Value & Access practice.