Documents for the Record

Subcommittee on Health Hearing
Lowering Health Care Costs for All Americans: An Examination of the Prescription Drug Supply Chain
February 11, 2026

Majority:

1. February 11, 2026, letter to Chairman Griffith and Ranking Member DeGette from Tom Kraus, Vice President of Government Relations, American Society of Health-System Pharmacists.
2. July 22, 2025, article by 46brooklyn entitled "How PBMs can use private-labelled drug products as a great escape from antisteering policies" submitted by Rep. Joyce.
3. February 11, 2026, letter to Chairman Griffith, Vice Chair Harshbarger, Ranking Member DeGette, and Members of the Subcommittee from the Honorable French Hill submitted by Rep. Miller-Meeks.
4. February 11, 2026, statement from AHIP.
5. February 11, 2026, letter to Chairman Griffith and Ranking Member DeGette from the American Academy of Family Physicians.

Minority:

1. Feb. 11, 2026, statement from AHIP
2. Feb. 11, 2026, statement for the record from AARP
3. Feb. 11, 2026, statement for the record from the American Hospital Association
4. Feb. 11, 2026, statement for the record from the Campaign for Sustainable Rx Pricing.
5. Feb. 11, 2026, statement for the record from the American Cancer Society Cancer Action Network.
6. Feb. 11, 2026, statement for the record from Patients for Affordable Drugs Now.

February 11, 2026

The Honorable Chairman Morgan Griffith
The Energy and Commerce Committee
Health Subcommittee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Ranking Member Diana DeGette
The Energy and Commerce Committee
Health Subcommittee
2125 Rayburn House Office Building
Washington, DC 20515

Re: Hearing on Lowering Health Care Costs for All Americans: An Examination of the Prescription Drug Supply Chain

Dear Representatives Griffith and DeGette:

Thank you for holding this hearing examining the prescription drug supply chain and ways to decrease healthcare costs. Pharmacists are accessible and low-cost healthcare providers who offer essential services that can save Americans money. The American Society of Health-System Pharmacists (ASHP) is the largest association of pharmacy professionals in the United States, representing over 65,000 pharmacists, student pharmacists, and pharmacy technicians who work collaboratively with other providers in all patient care settings, including hospitals, ambulatory clinics, and health system community pharmacies. We have a number of recommendations to help lower healthcare costs in the drug supply chain.

Medicaid PBM Reform: Pharmacy benefit managers (PBMs) participating in Medicaid managed care have inserted themselves into the drug supply chain and increased costs to the federal government and state Medicaid programs by basing their reimbursement on the difference between drugs' list prices and net prices. Many provisions in the recently passed Continuing Resolution protected patients and providers from PBM practices that increase costs, but it failed to include legislation that has been supported and passed by the committee that would prohibit PBMs from benefiting from Medicaid spread pricing, as set forth in Rep. Buddy Carter's Drug Price Transparency in Medicaid Act of 2023 and PBM Reform Act of 2025. We recommend Congress prohibit PBMs from utilizing spread pricing in Medicaid managed care.

Prohibiting White and Brown Bagging: White bagging occurs when a PBM requires a patient's medication distributed through a narrow network of specialty pharmacies that are often affiliated with the PBM before the drugs are then sent to a site of care, such as a hospital, where they will be dispensed by a provider. Hospitals have strict quality controls. By circumventing the traditional, regulated hospital supply chain, white bagging raises patient safety risks, including diversion and drug spoilage. Brown bagging occurs when a PBM ships medications to a patient, who must then take the medication to the provider for administration. These medications typically require special storage and handling. White bagging and brown bagging put pharmaceuticals at risk of spoilage, contamination, and diversion, putting patients' health at risk. We recommend Congress prohibit PBMs from imposing white- and brown-bagging requirements on clinician-administered medications.

Expand Access to Biosimilars: Uptake of biosimilars lags behind coverage of small-molecule generic drugs. Insurers and their PBMs typically cover only one preferred brand of a given biologic product, excluding all other biosimilar products. This is contrary to how plans cover small-molecule generic drugs where they are required to cover all commercially available versions. We recommend Congress require that an individual or group plan, and its PBM, that covers multiple small-molecule generic drugs in a formulary, treat biosimilars in a similar fashion. Thus, an individual or group health plan, and its PBM, that covers a reference (brand name) biologic or any biosimilar of the reference product, must cover all biosimilars of that product.

Ensuring Patients Have Access to Affordable, Safe, and Effective Biologics and Drugs: Despite a determination by the Food and Drug Administration (FDA) that a biosimilar has "no clinically meaningful differences" between the biological product and the reference product in terms of safety, purity, and potency, federal law requires redundant switching studies to be performed for a product to be deemed interchangeable. These studies delay adoption of biosimilars and compromise patients' ability to access these lower-cost biosimilar products, despite FDA's previous determination that the products are safe and effective. The Biosimilar Red Tape Elimination Act (H.R. 5526) would eliminate the requirement for switching studies, making a biosimilar interchangeable with its reference product upon FDA approval, thus allowing pharmacists to dispense these safe and effective products to patients at lower cost than their reference products. We recommend Congress eliminate the requirement for switching studies**.**

IRA Reform: The prescription drug provisions of the Inflation Reduction Act (IRA) were meant to ensure Medicare beneficiaries have access to affordable medications. Unfortunately, the Centers for Medicare & Medicaid Services (CMS) implementation has undermined this goal and will increase medication purchasing costs for pharmacists and pharmacies by allowing manufacturers to sell medications intended for Medicare beneficiaries at much higher prices than the negotiated price. This places immense financial pressures on pharmacies and pharmacists, clearly not the intent of the IRA. We recommend Congress amend the IRA to clarify that drug price discounts must be provided upfront rather than through rebates that allow manufacturers to game the system and increase purchase prices for pharmacies and providers.

Prohibiting Patent Thickets: Patent thickets, which consist of additional patents filed on a single existing product, undermine access to affordable, life-saving treatments. The Eliminating Thickets to Increase Competition (ETHIC) Act (H.R. 3269) would limit manufacturers' ability to unfairly stall generic and biosimilar drug development through abusive patent litigation practices. As a result, more generics and biologics could be approved and made available to patients in a timely manner, without being delayed by meritless litigation intended to stifle competition. We recommend Congress prohibit the use of patent thickets by drug manufacturers to delay generic competition.

ASHP thanks you for holding this important hearing and considering our recommendations. We look forward to continuing to work with you to ensure seniors have access to care. If you have questions or if ASHP can assist your office in any way, please contact Frank Kolb at fkolb@ashp.org.

Sincerely,

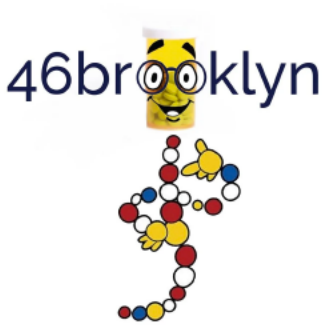
Tom Kraus
Vice President of Government Relations
American Society of Health-System Pharmacists

JULY 22, 2025

How PBMs can use private-labelled drug products as a great escape from anti-steering policies

Across every corner of U.S. healthcare, from end-of-life care to reproductive rights, patient choice sits squarely in the middle of many health policy questions. From a certain point of view, patient choice can be viewed as the DNA strand connecting America's ever-expanding, ever-adapting, healthcare ecosystem. And much like John Hammond or Curt Connors, when you mess with DNA, you face ethical quandaries. Advocates for patient choice highlight that patient autonomy is a moral right: the freedom to make informed, deeply personal choices about one's own body. Payers and policy wonks, however, point out that limitless choice can drive up costs, fracture care coordination, and dilute quality. The result is a perennial

formularies – lawmakers and stakeholders must decide, much like Hammond's Jurassic Park engineers, exactly how much control to resurrect and how much to place behind an electric fence.



In practice, lawmakers often try to balance the freedom to choose "any willing provider" with the economic realities of containing healthcare spending and ensuring equal access to care. In the private market, plan sponsors weigh similar trade-offs in attempting to curate their plan designs (to the degree with which they even realistically can). The end result is that regardless of the healthcare topic debated, patient choice seems to come up – as a rallying cry and/or negotiating chip that warps part of the policy discussion around its perspective. These debates over degrees of choice and coverage are directionally healthy – just like we can't pay infinite dollars for healthcare, we also can't pay nothing either. Thus, the field of play is ultimately centered on this friction between the patient's value assessments for their own care versus the plan's value assessments for controlling investment in care.

As a starting point, consider that Medicaid, under federal law, states that beneficiaries may obtain medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services." (Section 1902(a)(23) of Title XIX of the Social Security Act (the Act)). This provision is often referred to as the "any willing provider" or "free choice of provider" provision and extends from sea-to-shining-sea in the United States.

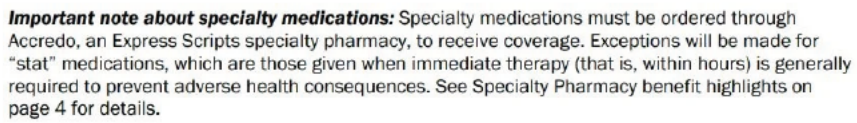
Alternatively, consider that as early as 1987, the Arkansas legislature passed Act 489. Generally considered the first pharmacy-specific "any willing provider" law adopted by a state, the act states that employers and insurers may not require mail-order pharmacy usage nor impose cost penalties for using local pharmacies. The Arkansas act triggered a wave of copycat bills throughout the early 1990s. Perhaps for that reason, when Medicare Part D came about in the mid-2000s, it also included a requirement that Part D sponsors must let any pharmacy that meets the plan's terms to join the retail network (see §1860D-4(b)(1)(A)).

An increasing number of states have enacted policies that attempt to prohibit a plan or pharmacy benefit manager (PBM) from forcing a patient to use a specific pharmacy or using cost-sharing penalties to nudge them to that specific pharmacy. By our unscientific count of this list from the National Conference of State Legislatures (NCSL), we tally just under 20 states with some form of "patient steering" extinction laws on the books.

And then of course, there's Arkansas (again), whose governor Sarah Huckabee-Sanders sent shockwaves nationally this year when she signed a law that essentially destroyed the PBM's ability to steer to patients to affiliated pharmacies simply by prohibiting PBMs from owning pharmacies at all in their state. The policy faced steep PBM opposition, who are now suing over it.

While true legislative intent can be speculated, in general, it is our opinion that the main premises of the first-in-the-nation Arkansas law are built on maximizing patient choice, eliminating conflicts of interest, and reducing costs (as PBM-affiliated pharmacies often receive higher estimated margins than their non-affiliated peers). Regardless, it is also our informed opinion that when state governments enact policies, they expect those policies to be followed in accordance with the intent.

With this legislative track record – and despite the fact that PBM executives have testified that they don't steer – patient steering issues still arise in states. Recent legislative efforts like those of Iowa highlight this. Iowa's latest PBM legislative activity would restrict common activities of payers and PBMs by removing the ability to require medications, like specialty drugs, to be dispensed at payer and/or PBM-affiliated pharmacies. As way of example, consider this PPO 800 plan from Express Scripts for Dell. As stated on page 1, specialty medications must be ordered through the PBM-affiliated Accredo pharmacy in order to receive coverage (**Figure 1**):



Important note about specialty medications: Specialty medications must be ordered through Accredo, an Express Scripts specialty pharmacy, to receive coverage. Exceptions will be made for "stat" medications, which are those given when immediate therapy (that is, within hours) is generally required to prevent adverse health consequences. See Specialty Pharmacy benefit highlights on page 4 for details.

Figure 1

Source: Express Scripts

In other words, if Dell members don't want to pay the full price for specialty medicines (think thousands to tens of thousands of dollars) by using the pharmacy of their choosing, they'll use Accredo or go without the benefit of their healthcare coverage to get them (unless they're in Iowa or other states with similar policies). So following the train of logic of the PBM executives who testified in Congress last year, it's not Express Scripts that is forcing patients to use Accredo for specialty drug coverage; but instead, it was Dell that had the idea to require their employees to use Accredo instead.

While the whodunit of it is fun and all, from a practical standpoint, pharmacies that attempt to fill prescriptions where payers and/or PBMs have put in-network restrictions are often greeted by messages like "Rejection Code AD: Billing Provider Not Eligible To Bill This Claim Type" or "Reject Code 76: Plan Limitations Exceeded" with a

eligible to dispense the medication. If effective, these state-level anti-steering laws would reject the use of those PBM reject codes for the purposes of requiring the medications be filled at a specific pharmacy.

But if you're familiar enough with PBM policy dynamics, you've probably heard the phrase "whack-a-mole" before, which is often used to explain the adept ability the industry has in working around the intent of legislation. Or maybe we should pin that on the plan sponsors too?

We learned this whack-a-mole dynamic the hard way in Ohio after the 2018 spread pricing saga unfolded. Unsurprisingly, legislative attempts to restrict PBM steering have also faced allegations of non-compliance (see Georgia for example).

You can't just suppress 65 million years of gut instinct.

Regardless of whether state anti-steering laws are good or bad, or currently working as intended or not, yet another tale as old as time has re-emerged: PBM vertical integration may provide yet another possible sanctuary to maneuver around the intent of state laws. And this time, the drug channel may be unearthing what many considered long-extinct remnants of a time long-forgotten where giant drug companies roamed the planet and intermingled DNA with their former foes in the PBM sector.

In today's drug pricing report, we explain how the advent of PBM private-label products – where PBM-affiliated companies essentially get in the pharmaceutical manufacturing and price-setting game – turn back time in a way that could represent a conveniently timed end-around

interests and incentives of PBMs to disproportionately provide highly marked up medicines to their affiliated pharmacies.

Welcome to Private Label Park.

PBM private labels: "We can make it if we run."

Private-label pharmaceuticals are medicines whose chemistry, dosage form, and FDA-mandated labeling text mirror a reference drug, but the bottle or carton carries a different National Drug Code (NDC) "labeler" prefix. Think of it like store-brand, sugar-coated corn flakes rather than name-brand Frosted Flakes. Historically, these store-brands were principally relegated to over-the-counter items available at the likes of Walmart, Target, or others.

Recently, PBMs have started to adopt their own "house brand" logic to pharmaceuticals by creating offshore

them in exclusive labels, and then prefer those products on their own formularies. For the historians in the room, this is basically the inverse of what happened in the 1990s with PBMs (where drug manufacturers were buying up PBMs; see Merck-Medco merger as example). Now PBMs are themselves becoming drug manufacturers. Said differently, private-label NDCs are the velociraptors testing the park's electric fences — probing for weaknesses in any willing provider and anti-steering laws. Consider the following regarding each of the big 3 PBMs:

PBM: Express Scripts | Parent Company: The Cigna Group. Formed in 2021 and domiciled in the Cayman Islands, Cigna's affiliate ***Quallent Pharmaceuticals*** started with commodity generics but evolved in 2024 to specialty biosimilars. In their own words, "the mission of Quallent Pharmaceuticals is to bring greater quality consistency and stability to our global pharmaceutical supply chain." While these private label arrangements can present a conflict of interest of sorts, it can also be true that private labelling can be a mechanism to lower the prices of drugs or shore up supply of medicines in the event of broader unavailability. On the latter point, for Cigna/ESI, we should acknowledge that of their list of 50+ available medications on Quallent's website, at least five products have seen FDA recalls (from other manufacturers of those drug products), and another five have seen FDA shortages since 2020 (i.e., the year before Quallent was founded). These are as follows:

- Metformin ER recall
- Lamotrigine recall
- Losartan recall
- Gabapentin recall
- Pravastatin recall
- Hydroxychloroquine shortage
- Sertraline shortage

- Capecitabine shortage
- Imatinib shortage

If you are a loyal 46brooklyn reader or a fan of Federal Trade Commission reports on PBMs, you might recognize this list as somewhat of a greatest hits album. Across the board, in our archives, you can find a bevy of information about metformin, lamotrigine, losartan, gabapentin, pravastatin, sertraline, tacrolimus, and capecitabine. And of course, who could forget imatinib and hydroxychloroquine, which were literally the first two reports we ever published here at 46brooklyn.

PBM: CVS Caremark | Parent Company: CVS Health. Launched in 2023 and headquartered in Ireland, CVS Health's ***Cordavis*** co-develops biosimilars with manufacturers. In their own words, "Cordavis makes strategic investments to bring pharmaceutical products to the U.S. market to increase competition and lower costs." Of course, from a WAC pricing standpoint, cheaper adalimumab products do exist to those offered by Cordavis (**Figure 2**).

HUMIRA AND ITS BIOSIMILARS, PRICE AND PBM FORMULARY COVERAGE, 2025

Product name	Manufacturer	WAC (2024)	WAC vs. Humira	Express Scripts	CVS Caremark	Optum Rx
Humira	AbbVie	$6,922	n.a.	–[4]	–[5]	–/✓[6]
Humira	Cordavis[7] (AbbVie)	$6,922	–0%	–	–	–
Simlandi[1,2]	Alvotech/Teva	$1,038	–85%	✓	–	–
adalimumab-ryvk[1,2]	Quallent[8] (Alvotech/Teva)	$3,750	–46%	✓	–	–
Amjevita[1] (High WAC)	Amgen	$6,576	–5%	–	–	✓[3]
Amjevita[1] (High WAC)	Nuvaila[9] (Amgen)	$6,576	–5%	–	–	–
Amjevita[1] (Low WAC)	Amgen	$3,115	–55%	–	–	–
Amjevita[2] (Low WAC)	Amgen	$1,385	–80%	–	–	–
Amjevita[2] (Low WAC)	Nuvaila[9] (Amgen)	$1,385	–80%	–	–	✓
Hulio	Biocon Biologics	$6,576	–5%	–	–	–
adalimumab-fkjp	Biocon Biologics	$995	–86%	–	–	–
Cyltezo[1,2]	Boehringer Ingelheim	$6,576	–5%	✓	–	–
adalimumab-adbm[1,2]	Boehringer Ingelheim	$1,315	–81%	–	–	–
adalimumab-adbm[1,2]	Quallent[8] (Boehringer Ingelheim)	$3,750	–46%	✓	–	–
Yuflyma[2]	Celltrion	$6,576	–5%	–	–	–
Yusimry[2]	Meitheal[10]	$995	–86%	–	–	–
Idacio	Fresenius Kabi	$6,576	–5%	–	–	–
adalimumab-aacf	Fresenius Kabi	$899	–87%	–	–	–
Abrilada[1] (High WAC)	Pfizer	$6,576	–5%	–	–	–
Abrilada[1,11] (Low WAC)	Pfizer	$1,038	–85%	–	–	–
Hadlima[2]	Samsung Bioepis/Organon	$1,038	–85%	–	–	–
Hyrimoz[1,2]	Sandoz	$6,576	–5%	–	✓	–
Hyrimoz[1,2]	Cordavis[7] (Sandoz)	$1,300	–81%	–	✓	–
adalimumab-adaz[1,2]	Sandoz	$1,315	–81%	✓	✓	–

WAC = wholesale acquisition cost
1. Indicates product is interchangeable with Humira reference product for one or more product strength.
2. Indicates product is available in high concentration formulation.
3. Amjevita (high WAC) is on Optum Rx's Premium and Select formularies, but excluded from its Premium Value formulary. Boehringer Ingelheim's adalimumab-adbm is on the Premium Value formulary.
4. As of January 2025, Express Scripts excluded Humira for new patients. As of July 2025, Express Scripts will exclude Humira from its preferred national formulary for all utilizers.
5. In April 2024, CVS Caremark removed Humira from its major commercial formularies. The reference product remains on CVS Caremark's Choice and Standard Opt Out commercial formularies, which account for a small share of its customers and covered lives.
6. As of January 2025, Optum Rx excluded Humira from its Premium Standard formulary, but includes it on tier 3 with prior authorization on its Select Standard formulary.
7. Cordavis is a subsidiary of CVS Health, which also operates CVS Caremark. The co-branded product made by AbbVie is not a biosimilar, because it is supplied by the manufacturer of the reference product.
8. Quallent Pharmaceuticals is a subsidiary of Cigna's Evernorth business, which also operates Express Scripts.
9. Nuvaila is a subsidiary of Optum, which also operates Optum Rx. The Nuvaila products launched in 2025.
10. In 2024, Coherus divested Yusimry to Hong Kong King-Friend Industrial Co., which markets the product via its Meitheal subsidiary.
11. In August 2024, Pfizer lowered the WAC of low WAC Abrilada from $2,769 to $1,038 for a 28-day supply.
Source: Drug Channels Institute research. Published on *Drug Channels* (www.DrugChannels.net) on January 22, 2025.

DRUG CHANNELS INSTITUTE

Figure 2

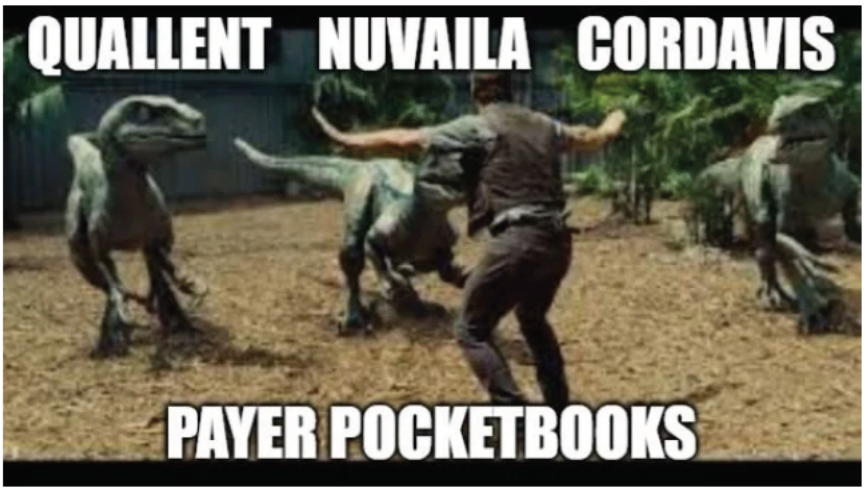
Source: Drug Channels Institute

While Cordavis' initial splash involved its Humira biosimilar, Hymiroz, this year, they have expanded its strategic biosimilar portfolio by wading into the Stelara biosimilar war with Pyzchiva.

PBM: Optum Rx | Parent Company: UnitedHealth Group. Trademarked in 2024 and also based in Ireland, ***Nuvaila*** (sometimes also referred to as Optum Health Solutions), which is part of the UnitedHealth Group conglomerate (legend has it that if you say their name in a public forum, they may magically appear), is a "pharmaceutical commercialization business" that seeks to ensure a reliable supply of therapies, create a strong supply chain, and uncover opportunities to reduce cost (per their website).

In addition to their Humira biosimilar, Optum/Nuvaila is also

So, in quick summation, Quallent, Nuvaila and Cordavis are here to help secure robust supplies of pharmaceuticals and reduce costs (Quallent does not appear to explicitly say reduce costs on its website like Nuvaila and Cordavis do).



"You are acting like we are engaged in some kind of mad science, but we are doing what we have done from the beginning."

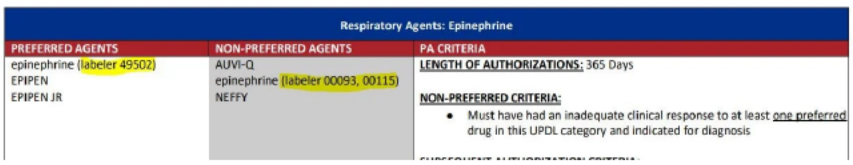
What we find interesting is that armed with these private label products – regardless of whether these arrangements can provide savings versus alternative arrangements or not – PBMs are positioned to pursue steering of products to their affiliated pharmacies without likely running afoul of the letter of anti-steering laws. This is because they can secure for themselves the sole-source position of these specific drug products, place them on formularies that their own vertically-integrated company creates, and then require that the specific NDC must be selected in order for the claim to adjudicate within the pharmacy network that their own vertically-integrated company creates as well.

In essence, the limited availability of a specific NDC of a drug product at PBM-affiliated pharmacies (as the entities who can be solely able to purchase the product) results in

restricting the sale of the medication at a specific pharmacy (at least that is our understanding, as we have yet to see evidence of products produced through Cordavis or Quallent being dispensed to any material degree at any pharmacy but those affiliated with the vertical company [CVS Health and Express Scripts/Cigna respectively]).

Conceptually, preferring one NDC of a drug versus another can be a reasonable strategy to ensure a plan is covering the most cost-effective therapies that are available and pushing out the ones that aren't. If there are two NDCs of the same interchangeable product, but Product A has an average wholesale price (AWP) per unit of $1,000 and Product B has an AWP per unit of $500, an aligned PBM may deploy utilization management tools like an NDC exclusion to ensure that Product A is excluded from coverage, Product B is preferred, and thus the plan could maximize savings if paying at a commonly-utilized AWP-based discount (e.g., AWP - 85% will produce a lower net cost on the $500 Product B vs. the $1,000 Product A).

These types of PBM tools are commonplace. As of 2021, IQVIA found that "compounded year-over-year annual growth for NDC exclusions has been greater than 50 percent, with more and more brands facing blocks every year." On the public program side, Medicaid programs have used NDC-based allowances or restrictions on their formularies for years. See Ohio Medicaid's current formulary, where specific generic epinephrine products are preferred or restricted based upon the NDC-code (The labeler codes highlighted represent the first five digits of the NDC on the claim; so epinephrine with a NDC 49502-****-** will process as an approved claim, whereas others will not):



Respiratory Agents: Epinephrine		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
epinephrine (labeler 49502) EPIPEN EPIPEN JR	AUVI-Q epinephrine (labeler 00093, 00115) NEFFY	LENGTH OF AUTHORIZATIONS: 365 Days NON-PREFERRED CRITERIA: • Must have had an inadequate clinical response to at least one preferred drug in this UPDL category and indicated for diagnosis

Figure 3
Source: Ohio Department of Medicaid

Of course, commercial and Medicaid programs are generally not engaged in directly purchasing and sourcing these labeler products, and participating network pharmacies can generally access the products their payer base is asking them to dispense. So the question becomes what, if any, financial advantage may be gained from these private label products. As a particular concern at the outset is that if you're the entity setting the formulary – who can impose NDC-specific restrictions to products only you can source (i.e., your own private label products sourced to ensure you have a robust supply of medication) – well, then you better be sure that your pricing of those products makes reasonable and rational sense.

"'Ooh, ahh.' That's how it always starts. But then later, there's running and screaming."

Much has been made of the PBMs' private label products of biosimilar Humira and Stelara. Humira was the top selling drug by revenues of the last decade, with Stelara up there in the mix as well. But biosimilars for those products didn't really start to gain traction until the last year (which makes retrospective analysis difficult, as we don't always have data readily available from stuff that recently transpired). For example, Medicare only just published its data through 2023, and groups like CVS didn't really adopt biosimilar Humira until April 2024. But let's see what we can make of the data we have, thanks to information in the public domain for Medicare, Medicaid, and the Commercial markets.

Medicare

Using Medicare as a judge, according to the 46brooklyn Medicare Part D Dashboard (which essentially a more souped up version of CMS's dashboard) for 2023, the

gross expenditures (out of $275 billion in total gross expenditures). If the big 3 PBMs manage approximately 80% of all prescription volumes (it's more when you consider their rebate aggregator alliances), the private label strategy stands to be worth billions of dollars annually (80% of $9 billion is $7.2 billion). Assuming that PBM private label products provide an 80% discount on historic spending (an approximation of what **Figure 2** is showing via list prices), then you're looking at ~$5.7 billion in an addressable market for the private label products annually for Medicare (caveats include an assumed flat utilization of products which may not be likely as price decrease and number of individuals enrolled in Medicare grows).

However, while we will wait to see how Medicare adoption of these PBM private label biosimilars play out over the coming years (we estimate that it will be until May 2026 until we see Medicare's 2024 utilization data), we can get an early insight into potential PBM private label activities by evaluating Quallent Pharmaceuticals. Why? Because Quallent has been around the longest (since 2021) and actually has utilization in Medicare in both 2022 and 2023; so we can monitor what the growth of PBM private label products might look like based upon what we can see in public data that is tagged to Quallent.

According to the Medicare Part D Dashboard, Quallent Pharmaceuticals had no utilization of any products in Medicare in 2021. In 2022, the dashboard shows that Quallent products were used to fill 1,991,271 Medicare prescriptions at a value of $42.8 million, whereas in 2023, Quallent products were used to fill 5,262,100 Medicare prescriptions (+164%) at a gross cost of $129.9 million (+204%) (**Figure 4**). That amount of growth is impressive.

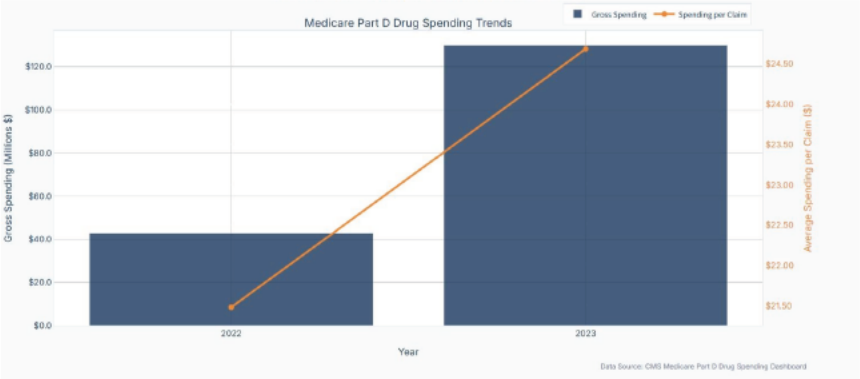


Figure 4

Source: Medicare Part D Dashboard

In researching, of the 900 or so drug labelers in the Medicare Part D Dashboard, only 64 matched or exceeded Quallent's level of prescription utilization growth, and only 59 matched or exceeded Quallent's level of spending growth. If we rank those matching or exceeding Quallent's dollar growth percentage by the total gross Medicare dollars spent in 2023, we see that only three actually had more gross spending than Quallent (**Figure 5**).

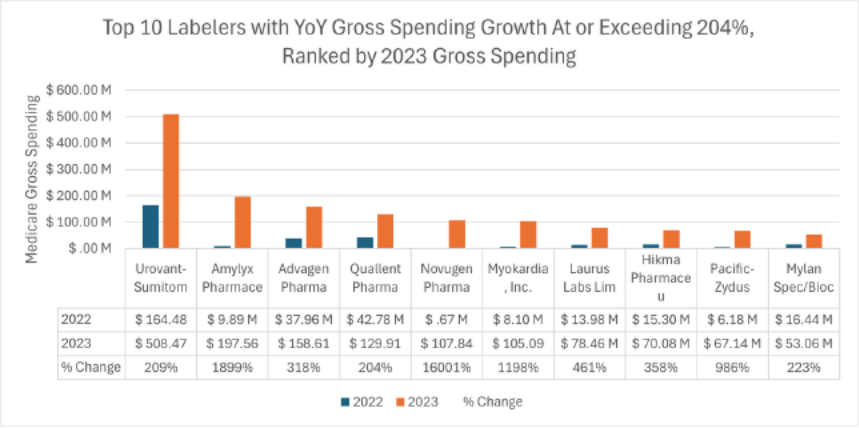


Figure 5

Source: Medicare Part D Dashboard

In other words, just because your spending increases 312%, it isn't that meaningful if your $368 in 2022 increases to $1,517 in 2023 (see Prugen Pharmaceuticals in Part D 2023 Dashboard as an example). To us, these initial results signal

Medicare, **as Quallent appears to quickly becoming one the prominent players in the drug manufacturing and labelling industry.**

While Quallent offers 50+ products according to their website, the Medicare data suggests that 43 products were utilized in Medicare in 2023. The total expenditures on these 43 products across all labelers (Quallent plus other manufacturers of interchangeable versions of those drugs) was a gross $10.5 billion in Medicare throughout 2023. To pause here for a moment, we find this impressive by itself considering that these products represent a similar addressable market to what we already highlighted with Humira and Stelara (these 43 products have gross Medicare spending similar to the combined Humira and Stelara market within the program). In other words, while the other PBMs are catching up to Cigna/ESI's private label endeavors, Quallent may have already carved itself a T-Rex-sized territory of private label products equal to the Humira/Stelara market that the PBMs are getting all the attention for right now.

On a per unit basis, 23 of the 43 products Quallent offers had a higher unit price than all the aggregate unit prices of all other labelers for that product in Medicare in 2023. As way of example, the average 2023 unit price for imatinib mesylate in Medicare for Quallent products was $103 per pill (Gross Medicare 2023 Expenditures / Number of Dosage Units), whereas the unit price for imatinib mesylate for all non-Quallent products was an aggregated $40.41 per pill (ranging from $2.31 per pill to $60.96 per pill; see **Figure 6**).

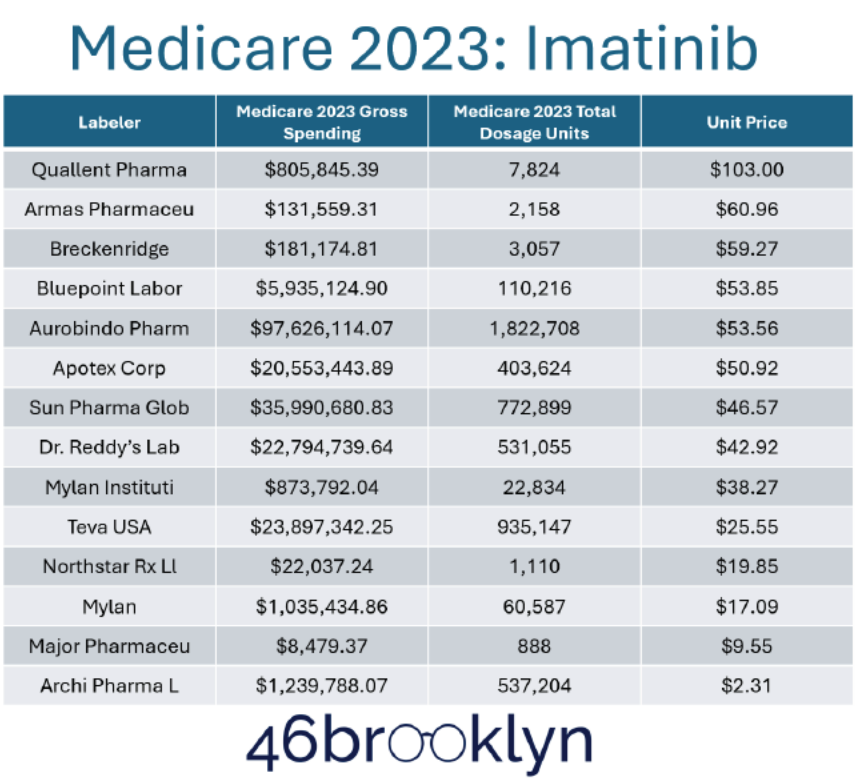
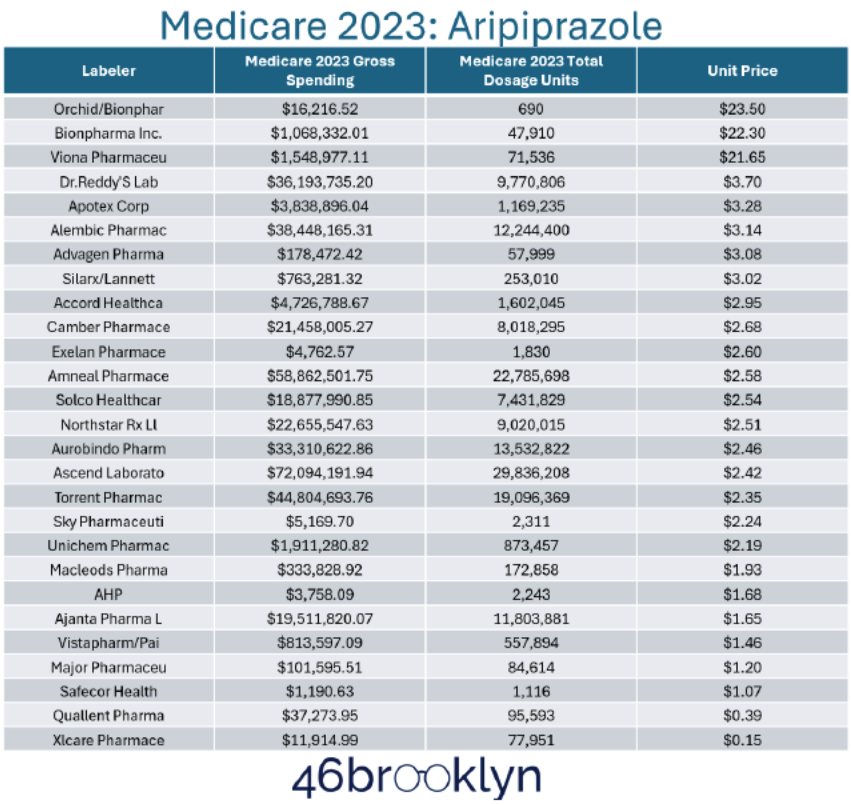


Figure 6

Source: *Medicare Part D Dashboard*

Alternatively, 17 of the 43 products showed that the Quallent unit price was cheaper than the competitors (meaning three products were effectively a wash). As way of example, the average 2023 unit price for aripiprazole in Medicare for Quallent products was $0.39 per pill, whereas the unit price for aripiprazole for all non-Quallent products was $2.52 per pill (range from $0.15 per pill to $23.50 per pill; see **Figure 7**).



Medicare 2023: Aripiprazole

Labeler	Medicare 2023 Gross Spending	Medicare 2023 Total Dosage Units	Unit Price
Orchid/Bionphar	$16,216.52	690	$23.50
Bionpharma Inc.	$1,068,332.01	47,910	$22.30
Viona Pharmaceu	$1,548,977.11	71,536	$21.65
Dr.Reddy'S Lab	$36,193,735.20	9,770,806	$3.70
Apotex Corp	$3,838,896.04	1,169,235	$3.28
Alembic Pharmac	$38,448,165.31	12,244,400	$3.14
Advagen Pharma	$178,472.42	57,999	$3.08
Silarx/Lannett	$763,281.32	253,010	$3.02
Accord Healthca	$4,726,788.67	1,602,045	$2.95
Camber Pharmace	$21,458,005.27	8,018,295	$2.68
Exelan Pharmace	$4,762.57	1,830	$2.60
Amneal Pharmace	$58,862,501.75	22,785,698	$2.58
Solco Healthcar	$18,877,990.85	7,431,829	$2.54
Northstar Rx Ll	$22,655,547.63	9,020,015	$2.51
Aurobindo Pharm	$33,310,622.86	13,532,822	$2.46
Ascend Laborato	$72,094,191.94	29,836,208	$2.42
Torrent Pharmac	$44,804,693.76	19,096,369	$2.35
Sky Pharmaceuti	$5,169.70	2,311	$2.24
Unichem Pharmac	$1,911,280.82	873,457	$2.19
Macleods Pharma	$333,828.92	172,858	$1.93
AHP	$3,758.09	2,243	$1.68
Ajanta Pharma L	$19,511,820.07	11,803,881	$1.65
Vistapharm/Pai	$813,597.09	557,894	$1.46
Major Pharmaceu	$101,595.51	84,614	$1.20
Safecor Health	$1,190.63	1,116	$1.07
Quallent Pharma	$37,273.95	95,593	$0.39
Xlcare Pharmace	$11,914.99	77,951	$0.15

Figure 7

Source: Medicare Part D Dashboard

Whether Quallent products were associated with savings or not largely depended upon which product we chose to look at, which if we're honest, isn't really a satisfying answer. If, as large PBMs claim, they're the only ones working to lower prescription drug prices, we would expect them to have lowest price in all instances – or at least close to the lowest price – given their size and leverage. After all, by launching their own private labels, they've effectively taken over the role of who they say is to blame for high prices: the pharmaceutical company. And as PBMs like to remind us, the drug manufacturer and the drug manufacturer alone sets the drug's price; so when PBMs enter the manufacturing and price-setting realm as private labelers, why aren't their prices materially lower across the board? Or are the plan sponsors to blame for setting the prices of their drugs too?

Taking imatinib as an example, Mark Cuban in 2023 was able

in 2023 (or roughly the cost of six imatinib pills from Quallent **per Medicare's spending data**; i.e., less than one week's worth of medication). How could Cuban's Cost Plus Drugs be doing so much better of a job managing imatinib costs in 2023 than the titanosaur of pharmacy benefits Express Scripts?

Well, to evaluate whether Quallent prices were net good or net bad, we decided to perform an analysis that evaluated what would happen to Medicare expenditures if the Quallent unit price prevailed for all units of the various products at issue in Medicare in 2023. To do this, we took our calculated unit price for Quallent and determined its premium relative to the calculated unit price for the aggregated experience of all other non-Quallent labelers in Medicare in 2023. In the below chart, if Quallent was more expensive, the value appears as a positive premium, whereas if Quallent was less expensive than the aggregate Medicare experience, then the value shows a negative. We then multiplied this calculated premium value by all Medicare units dispensed in 2023 to get the net impact to Medicare. As shown in **Figure 8** below, if Medicare's prices for all the drugs that were available through Quallent in 2023 were to effectively be changed to Quallent's prevailing prices at the time, Medicare's expenditures would rise around $1.2 billion, or 11% on Medicare's $10.5 billion gross expenditures on those medicines from 2023.

Medicare 2023: Repricing of Quallent "Premium"

Product Name	Unit Price (Quallent)	Unit Price (Non-Quallent Labelers)	Quallent Premium (Quallent - Non-Quallent)	Net Impact
Gabapentin	$0.24	$0.15	$0.09	$417,002,248.78
Imatinib Mesylate	$103.00	$40.41	$62.58	$126,142,588.82
Tadalafil	$18.25	$6.04	$12.41	$106,365,237.28
Atorvastatin Calcium	$0.23	$0.20	$0.03	$153,024,880.48
Metoprolol Succinate	$0.30	$0.26	$0.05	$108,885,298.34
Metformin HCl	$0.10	$0.07	$0.03	$107,317,780.82
Lisinopril	$0.16	$0.12	$0.04	$105,890,853.13
Metformin HCl ER	$0.14	$0.08	$0.06	$94,027,842.24
Losartan Potassium	$0.22	$0.19	$0.03	$84,362,191.90
Simvastatin	$0.21	$0.14	$0.07	$78,662,296.24
Amlodipine Besylate	$0.14	$0.12	$0.02	$75,781,171.94
Sildenafil Citrate	$4.76	$1.76	$2.99	$74,478,895.41
Bupropion XL	$0.61	$0.52	$0.09	$56,183,335.02
Carvedilol	$0.10	$0.08	$0.01	$29,654,539.99
Fenofibrate	$0.66	$0.56	$0.09	$28,236,843.73
Levetiracetam*	$0.31	$0.27	$0.04	$25,788,699.27
Pioglitazone HCl	$0.36	$0.26	$0.10	$23,586,497.33
Escitalopram	$0.30	$0.27	$0.02	$12,531,455.73
Fluoxetine HCl	$0.22	$0.20	$0.02	$10,643,224.83
Rosuvastatin Calcium	$0.22	$0.21	$0.00	$9,700,908.91
Meloxicam	$0.16	$0.14	$0.02	$8,815,929.66
Quetiapine Fumarate	$0.43	$0.41	$0.02	$8,142,676.44
Citalopram HBr	$0.16	$0.15	$0.01	$5,935,050.29
Omeprazole	$0.20	$0.20	$0.00	
Lansoprazole	$0.20	$0.20	$0.00	
Clopidogrel	$0.25	$0.24	$0.00	
Lamotrigine	$0.62	$0.66	-$0.04	-$5,070,698.52
Pravastatin Sodium	$0.24	$0.26	-$0.01	-$9,355,101.88
Finasteride	$0.21	$0.25	-$0.02	-$11,536,893.04
Topiramate	$0.14	$0.18	-$0.04	-$11,563,031.33
Hydroxychloroquine Sulfate	$0.07	$0.14	-$0.07	-$17,147,372.81
Tacrolimus*	$1.07	$1.48	-$0.31	-$18,389,853.40
Montelukast Sodium	$0.22	$0.25	-$0.03	-$19,536,859.09
Escitalopram Oxalate	$0.20	$0.26	-$0.05	-$22,048,947.20
Valacyclovir	$0.81	$0.90	-$0.10	-$22,757,205.65
Venlafaxine HCl ER	$0.36	$0.47	-$0.09	-$38,393,155.54
Esomeprazole Magnesium	$0.70	$0.91	-$0.20	-$54,041,359.74
Tamsulosin HCl	$0.23	$0.25	-$0.02	-$38,527,320.27
Pantoprazole Sodium*	$0.21	$0.23	-$0.02	-$45,230,404.16
Donepezil HCl	$0.18	$0.32	-$0.14	-$51,730,283.62
Sertraline HCl	$0.12	$0.18	-$0.06	-$53,734,442.29

CART (0)

Figure 8
Source: Medicare Part D Dashboard

The figure above suggests that, left to make their own drug pricing and sourcing decisions, PBMs (and/or their plan sponsors) would see Medicare pay them more, not less, for prescription drugs (at least, if Quallent's pricing is to be the measuring stick). To be clear, we don't think this is a surprising finding. PBMs after all are businesses, just like every other layer of the drug channel, and businesses want to be paid more; not less. From a certain point of view, perhaps this analysis supports the view that it *is* the drug manufacturer's fault that drug prices are so high, as the PBM-affiliated manufacturer product lines seem to prefer/set/favor/effectuate (or whatever other word you're comfortable with) higher prices; not lower (at least in the aggregate). Said differently, if Quallent wasn't a labeler for imatinib prescriptions in Medicare 2023, odds are good that the Medicare member and/or plan would have seen a lower imatinib price (given that the aggregate non-Quallent price experience for that product was lower than the observed Quallent price; no one was higher than Quallent per **Figure 6**).

Of course, Medicare represents just one way to view the drug pricing world. Others exist that we can also use to try to unravel the mysteries of Quallent's drug pricing.

Medicaid

Many tell us Medicare is the end-all-be-all program for drug pricing analysis; however, we cannot help but to assess the Quallent experience in Medicaid as well. After all, 46brooklyn largely got its start studying Medicaid data (you might say it's in our DNA). How could we not look under the hood?

What's wild is we don't get the same answer or experience if

To start, growth of Quallent Pharmaceuticals sales has not been as impressive dollar-wise in Medicaid as it has been in Medicare (though on a percentage basis, it is perhaps more impressive). Per CMS State Drug Utilization Data (SDUD), in 2022, there were just $38K in total gross expenditures on Quallent products in Medicaid programs across the nation, and by 2024, there were $2.5 million in total gross expenditures (which while a 6,000+% rate of growth, is less than 2% of the expenditures on Quallent in Medicare in 2023 [as stated earlier, $129 million was spent on Quallent in Medicare in 2023]). On a prescription basis, there were just 1,988 Quallent-sourced prescriptions filled in Medicaid in 2022, which has grown to 16,251 prescriptions in 2024 (713% growth, but less than 1% of the number of prescriptions for Quallent products in Medicare in 2023 [again, 5 million+ prescriptions of Quallent products were filled in Medicare in 2023]).

As previously identified, although Quallent offers 50+ products according to their website, the SDUD suggests that only 41 products were utilized in Medicaid in 2024. The total expenditures on these 41 products across all labelers was a gross $1.5 billion in Medicaid throughout 2024. On a per unit basis, just eight of the 41 products Quallent offers had a higher unit price than all other labelers for the product in Medicaid in 2024. Conversely, 33 had lower prices. Performing the same type of premium analysis as we did in Medicare (see lead up to **Figure 8**) yields significantly different results with the Medicaid data (**Figure 9**).

Medicaid 2024: Repricing of Quallent "Premium"

Product Name	Unit Price (Quallent)	Unit Price (Non-Quallent Labelers)	Quallent Premium (Quallent - Non-Quallent)	Net Impact
Gabapentin	$0.23	$0.19	$0.04	$15,458,458.37
Capecitabine	$4.54	$2.08	$2.46	$5,981,812.42
Quetiapine	$0.33	$0.23	$0.10	$5,796,190.25
Dimethyl Fumarate	$14.53	$10.06	$4.47	$5,155,868.78
Simvastatin	$0.25	$0.19	$0.07	$4,757,354.04
Omeprazole	$0.23	$0.23	$0.01	$2,146,983.02
Tadalafil	$4.79	$4.23	$0.59	$745,769.23
Sildenafil	$0.62	$0.55	$0.07	$322,865.82
Valacyclovir	$0.44	$0.47	-$0.02	-$886,965.19
Lamotrigine	$0.29	$0.21	$0.01	$1,450,334.64
Hydroxychloroquine	$0.29	$0.32	-$0.04	-$1,649,310.17
Levetiracetam	$0.16	$0.18	-$0.02	-$1,797,758.51
Fenofibrate	$0.22	$0.31	-$0.09	-$1,864,996.32
Citalopram	$0.17	$0.23	-$0.05	-$2,095,110.06
Losartan	$0.18	$0.28	-$0.01	-$2,131,859.49
Tacrolimus	$0.29	$0.35	-$0.06	-$2,998,241.05
Clopidogrel	$0.22	$0.27	-$0.05	-$3,303,681.58
Pantoprazole	$0.25	$0.26	-$0.01	-$3,327,316.73
Pingsimod	$21.40	$40.31	-$18.92	-$3,545,344.55
Tamsulosin	$0.22	$0.26	-$0.04	-$3,877,147.54
Ezetimibe	$0.21	$0.30	-$0.09	-$4,108,596.06
Imatinib	$2.50	$11.17	-$8.67	-$4,550,792.83
Metoprolol	$0.21	$0.23	-$0.02	-$4,673,973.16
Abiraterone	$1.77	$6.12	-$4.36	-$5,146,347.59
Montelukast	$0.23	$0.26	-$0.03	-$5,280,365.50
Carvedilol	$0.07	$0.13	-$0.06	-$7,109,719.58
Rosuvastatin	$0.29	$0.25	-$0.04	-$7,620,056.27
Aripiprazole	$0.19	$0.41	-$0.23	-$7,981,798.47
Fluoxetine	$0.18	$0.22	-$0.03	-$8,722,190.69
Ambrisentan	$31.04	$48.99	-$17.95	-$10,451,391.55
Topiramate	$0.09	$0.19	-$0.07	-$11,820,499.97
Metformin	$0.09	$0.19	$0.01	-$12,986,252.21
Atorvastatin	$0.23	$0.22	-$0.02	-$13,338,332.65
Meloxicam	$0.12	$0.24	-$0.12	-$14,477,081.36
Emtricitabine-Tenofovir	$0.64	$3.04	-$2.40	-$16,299,601.93
Bupropion	$0.26	$0.35	-$0.09	-$17,780,069.34
Escitalopram	$0.18	$0.27	-$0.08	-$17,850,800.98
Sertraline	$0.17	$0.23	-$0.05	-$19,871,498.76
Duloxetine	$0.18	$0.30	-$0.12	-$21,768,693.44
Amlodipine	$0.13	$0.19	-$0.06	-$22,117,212.38
Lisinopril	$0.13	$0.19	-$0.06	-$23,875,260.96

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Figure 9

Source: CMS State Medicaid Drug Utilization, 2024

As shown in **Figure 9**, if Medicaid's prices for all the drugs that were available through Quallent in 2024 were to effectively be changed to Quallent's prevailing prices at the same time, Medicaid's expenditures would decline around $245 million, or 16% less than what Medicaid spent on these therapies across all suppliers in 2024. While there are some products that overlap between the list with similar experience (i.e., both gabapentin and quetiapine appear to be net premium products), others differ significantly (such as the age-old favorite imatinib being a cost-increaser in Medicare but a cost-saver in Medicaid).

Of course, the aggregate experience can conceal some of the detailed realities. If we break the Medicaid experience out by state, some of the drugs that are Quallent cost-savers in the national aggregate can be more costly depending upon where you live. Let's take a look at lisinopril, the biggest Quallent-sourced Medicaid cost-saver in **Figure 9**. Quallent NDCs for lisinopril were dispensed in just five

While Quallent products resulted in savings in the aggregate and for the majority of these states, it was a significant premium when used in Michigan and a small premium when used in Texas (**Figure 10**).

Medicaid 2024: Lisinopril

State	Medicaid Expenditures	Medicaid Units	Unit Price
Illinois	**$2,071,391.93**	**16,092,171**	**$0.13**
Non-Quallent	$2,068,923.00	16,069,258	$0.13
Quallent	$2,468.93	22,913	$0.11
Michigan	**$1,295,819.91**	**15,156,787**	**$0.09**
Non-Quallent	$1,295,393.06	15,154,957	$0.09
Quallent	$426.85	1,830	$0.23
Minnesota	**$1,154,916.65**	**4,088,046**	**$0.28**
Non-Quallent	$1,154,334.47	4,084,506	$0.28
Quallent	$582.18	3,540	$0.16
New Mexico	**$4,557,008.91**	**5,096,835**	**$0.89**
Non-Quallent	$4,556,811.51	5,095,755	$0.89
Quallent	$197.40	1,080	$0.18
Texas	**$912,050.08**	**7,551,413**	**$0.12**
Non-Quallent	$911,883.51	7,550,093	$0.12
Quallent	$166.57	1,320	$0.13

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Figure 10

Source: CMS State Medicaid Drug Utilization, 2024, Lisinopril

And before you ask, we're not sure how some states got better Quallent pricing than others. As you can see, average non-Quallent Medicaid prices in these states for lisinopril ranged from $0.09 per pill to $0.89 per pill, while average Quallent lisinopril prices in these states ranged from $0.11 per pill to $0.23 per pill. While we're presenting the information above in a manner similar to what Medicare does to try to be consistent, Medicaid does give us the ability to break out these rolled up products into individual strengths and dosage forms. However, even taking advantage of the additional detailed data (**Figure 11**) in Medicaid, we directionally see the same thing **Figure 10** is showing (**Figure 11** reproduces the results of **Figure 10**, but puts each lisinopril product line under each state).

Medicaid 2024: Lisinopril

State	Product	Quallent Unit Price	Non-Quallent Unit Price	Quallent Premium
Illinois	Lisinopril Tab 10 MG	$ 0.09	$ 0.11	-$0.02
	Lisinopril Tab 2.5 MG		$ 0.11	
	Lisinopril Tab 20 MG	$ 0.11	$ 0.11	$0.00
	Lisinopril Tab 40 MG	$ 0.14	$ 0.14	$0.00
	Lisinopril Tab 5 MG	$ 0.09	$ 0.11	-$0.02
Michigan	Lisinopril Tab 10 MG		$ 0.07	
	Lisinopril Tab 2.5 MG		$ 0.05	
	Lisinopril Tab 20 MG		$ 0.08	
	Lisinopril Tab 40 MG	$ 0.23	$ 0.10	$0.13
	Lisinopril Tab 5 MG		$ 0.06	
Minnesota	Lisinopril Tab 10 MG	$ 0.12	$ 0.23	-$0.11
	Lisinopril Tab 2.5 MG		$ 0.13	
	Lisinopril Tab 20 MG	$ 0.11	$ 0.21	-$0.10
	Lisinopril Tab 40 MG	$ 0.26	$ 0.24	$0.02
	Lisinopril Tab 5 MG		$ 0.24	
New Mexico	Lisinopril Tab 10 MG		$ 0.84	
	Lisinopril Tab 2.5 MG		$ 0.53	
	Lisinopril Tab 20 MG	$ 0.18	$ 0.78	-$0.60
	Lisinopril Tab 40 MG		$ 0.85	
	Lisinopril Tab 5 MG		$ 1.05	
Texas	Lisinopril Tab 10 MG	$ 0.13	$ 0.12	$0.01
	Lisinopril Tab 2.5 MG		$ 0.11	
	Lisinopril Tab 20 MG		$ 0.10	
	Lisinopril Tab 40 MG		$ 0.19	
	Lisinopril Tab 5 MG		$ 0.11	

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Figure 11

Source: CMS State Medicaid Drug Utilization, 2024, Lisinopril

Looking at **Figure 11** compared to **Figure 10**, we reach no different conclusions from those we already drew. However, **Figure 11** does highlight the important role that our access to data, and the details therein, can potentially have in influencing our perceptions of drug pricing reality. Whether we roll up products or go down to specific strengths or dosage forms, we do not appear to be any closer to understanding the variability in prices we're observing. While variance for Medicaid programs broadly can be reasonably attributed to a multitude of factors like different mixes of pharmacies and manufacturers, it becomes a tad perplexing when the same company owns the manufacturer/labeler, the pharmacy, and the PBM negotiating the payment. Conventional wisdom would suggest that pricing would be aligned from state to state if the massive healthcare vertical that is manufacturer-to-

aggregate cost savings produced from Quallent's lisinopril, it seems strange that the same drug over the same time period from the same company could be more than twice as expensive from one state to another. Or looking back at imatinib, how can the yielded Quallent unit price in Medicare be 2.5x higher than the average of all other labelers of the product, but in Medicaid, all other labelers of imatinib are 4.5x higher than Quallent?

To underscore this point, whether we attribute the yielded pricing realities to the drug company, the pharmacy, the PBM, or some combination of each, with vertical integration, the experience is all rolled up to the same parent company. So how can the prices yielded by the parent company be so disparate from state to state or program to program?

We're honestly not sure. So we did what we always do and grabbed yet more data.

Commercial

For our last review, we ventured into the only other major market segment left: the commercial marketplace, which provides coverage to around half of all Americans. This time we grabbed the National Average Drug Acquisition Cost (NADAC) Reports from Evernorth (another component of the broader Cigna/Express Scripts parent company). These required public disclosures under a West Virginia law require PBMs to self-report instances where their drug pricing exceeds 10% (plus or minus) of the underlying NADAC costs for commercial plan sponsors. These reports offer a great deal of pricing transparency directly from the PBM's themselves (which we view as an absolute positive). Files on Evernorth's website range from Q1 2022 to Q1 2025 as of this writing. And while it would be great if we could roll forward the clock on these observations to Q1 2025, when we grabbed that file, we did not see any Quallent products. To be clear, no Quallent products hitting the +/- 10% of NADAC

that, we elected to select the 2023 files, as it would align with our Medicare data (the rate limiting step of observations is Medicare doesn't yet have 2024 data like Medicaid, plus Medicare pricing is often a closer approximation to Commercial claims than Medicaid). So, for this reason, we gathered all four quarters of 2023 files and merged them together.

We started as we did with the others: seeking to identify the number of Quallent products used in these West Virginia commercial plan sponsors and whether there was a premium or savings to be had with the Quallent product relative to everyone else. To start, we find that 38 Quallent products were used by West Virginia commercial plan sponsors in 2023 per Evernorth/Cigna/ESI's data. Of these, 12 had a premium relative to non-Quallent NDCs, and the remaining 26 were lower cost. All told, the total value in the net (Quallent-yielded prices minus Non-Quallent-yielded prices, multiplied by total units dispensed) was such that commercial plan sponsors saw aggregate net savings with Quallent products ($691K in savings; **Figure 12**). Relative to $14.99 million in observed drug cost expenditures for these products in 2023, this savings represents approximately 4.6% relative to the current spending on these products.

WV ESI NADAC Reports 2023: Repricing of Quallent "Premium"

Product Name	Unit Price (Quallent)	Unit Price (Non Quallent)	Quallent Premium	Net Impact
TADALAFIL	$27.29	$7.31	$19.98	$615,148.75
IMATINIB	$182.20	$108.50	$73.70	$249,850.95
GABAPENTIN	$0.16	$0.09	$0.07	$172,049.32
BUPROPION	$0.48	$0.42	$0.06	$153,187.92
ARIPIPRAZOLE	$0.52	$0.33	$0.20	$61,124.70
MONTELUKAST	$0.26	$0.24	$0.02	$51,918.97
VALACYCLOVIR	$0.66	$0.54	$0.12	$29,818.12
FLUOXETINE	$0.21	$0.19	$0.02	$29,079.31
ESCITALOPRAM	$0.19	$0.18	$0.01	$23,582.66
LEVETIRACETAM	$0.28	$0.24	$0.04	$20,273.65
MELOXICAM	$0.12	$0.10	$0.02	$18,339.62
TAMSULOSIN	$0.24	$0.22	$0.01	$12,364.01
SILDENAFIL	$1.02	$1.06	-$0.04	-$394.17
EZETIMIBE	$0.53	$0.53	$0.00	-$1,347.43
FENOFIBRATE	$0.55	$0.56	-$0.01	-$4,973.86
ESOMEPRAZOLE	$0.56	$0.57	-$0.01	-$5,021.92
CITALOPRAM	$0.12	$0.13	-$0.01	-$9,287.17
FINASTERIDE	$0.18	$0.26	-$0.08	-$11,578.89
CLOPIDOGREL	$0.18	$0.22	-$0.04	-$20,248.96
SIMVASTATIN	$0.18	$0.20	-$0.02	-$20,312.01
DULOXETINE	$0.33	$0.35	-$0.02	-$24,661.44
PIOGLITAZONE	$0.23	$0.38	-$0.15	-$30,580.58
PRAVASTATIN	$0.19	$0.24	-$0.05	-$37,124.13
HYDROXYCHLOROQUINE	$0.51	$0.61	-$0.10	-$46,536.38
LOSARTAN	$0.20	$0.22	-$0.02	-$47,750.37
AMLODIPINE	$0.09	$0.10	-$0.02	-$49,570.40
LISINOPRIL	$0.12	$0.13	-$0.01	-$65,696.55
LANSOPRAZOLE	$0.52	$0.81	-$0.29	-$76,786.16
TACROLIMUS	$0.32	$0.75	-$0.43	-$80,707.18
OMEPRAZOLE	$0.18	$0.20	-$0.02	-$85,108.47
PANTOPRAZOLE	$0.19	$0.23	-$0.04	-$110,223.09
CARVEDILOL	$0.08	$0.20	-$0.11	-$120,504.49
ATORVASTATIN	$0.20	$0.23	-$0.03	-$144,895.08
LAMOTRIGINE	$0.15	$0.34	-$0.18	-$184,927.51
TOPIRAMATE	$0.11	$0.29	-$0.17	-$190,036.05
ROSUVASTATIN	$0.27	$0.35	-$0.08	-$214,150.89
VENLAFAXINE	$0.31	$0.49	-$0.18	-$231,742.89
METFORMIN	$0.08	$0.12	-$0.05	-$313,880.79

46brooklyn

Figure 12

Source: Evernorth NADAC Reports, WV, 2023

So, as a starting point, commercial data appears to agree with Medicaid data in terms of overall direction of Quallent-sourced drug prices (but generally disagrees with Medicare). We can draw several additional details from the West Virginia data though.

First, we can confirm that Quallent products appear to be exclusively sold at Express Scripts-affiliated pharmacies, as across over 34,000 claims in the commercial database for Quallent products, all but one were dispensed by a pharmacy named either Express Scripts or Accredo.

Second, we can see on an individual basis how Quallent might play into the strategy of Express Scripts more broadly. In looking at the drug omeprazole for example, where the net

non-Quallent-sourced prices shows savings for commercial payers, when we zoom in, we can see that nearly all of the top-end prescriptions are being filled with Quallent NDCs. In **Figure 13**, we analyze all omeprazole prescriptions in the 2023 WV Commercial ESI NADAC reports where the payment was 20-fold or more higher than NADAC (the basis for WV commercial reporting is +/- 10% of NADAC, so we're looking for activity that is in an absolute extreme category relative to the reporting threshold). We select this threshold because it is where we first observe Quallent prescriptions (from a highest to lowest NADAC mark-up basis). What we find is that, of the 203 claims in the database where commercial plan sponsor prices for omeprazole were more than 20 times higher than the underlying average pharmacy acquisition cost for the drug (NADAC), 104 of them (51%) were Quallent NDCs. And of these, all were dispensed at Express Scripts pharmacy.

WV ESI NADAC Reports 2023: Omeprazole Claims Paid 20-fold or more than NADAC

Labeler Code	Pharmacy Name	Count of Fill Date	Average of Amount the Pharmacy was Reimbursed per Unit
55111	CVS #06276	2	$ 0.69
55111	EXPRESS SCRIPTS	84	$ 0.76
68382	MILLER BROTHERS PHARMACY	1	$ 4.91
68382	WALGREENS #11677	1	$ 3.63
68462	AMAZON PHARMACY #006	1	$ 0.70
68462	HARTS PHARMACY	2	$ 4.91
68462	MILLER BROTHERS PHARMACY	2	$ 4.91
68462	PILLPACK PHOENIX	1	$ 1.04
70700	WALGREENS #11293	1	$ 2.15
78128	EXPRESS SCRIPTS	4	$ 0.76
82009	EXPRESS SCRIPTS	104	$ 0.76
Grand Total		203	$ 0.88

46brooklyn

Figure 13

Source: Evernorth NADAC Reports, WV, 2023

And while **Figure 13** does identify that West Virginia-situated pharmacies like Walgreens or Miller Brothers got higher unit prices on omeprazole in 2023, they only got one (Walgreens) to three (Miller Brothers) prescription filled at those inflated omeprazole reimbursement prices ($4 per unit of omeprazole). And to be clear, Walgreens and Miller Brothers Pharmacy are likely only getting these omeprazole prices because they've submitted high Usual & Customary (U&C) prices asking to be paid lots of money for omeprazole

as the pharmacy's sticker or ceiling price, which are routinely over-inflated relative to the pharmacy's actual acquisition costs). But that brings us to a broader point, when reimbursement is a lottery as opposed to something more resembling one clear, market-clearing price, what incentives do we realistically expect pharmacy providers to follow? Ask most pharmacies and we think you'll find they'd rather get paid $0.76 per pill on 104 omeprazole prescriptions as opposed to $4.91 per pill on one or even three omeprazole prescriptions, ***but*** if you can only get three high-margin fills at $0.70 or more per unit, then we're willing to bet that you — if you were a pharmacy provider — would seek to maximize the profits you can get (especially when considering the frequent losses that pharmacies shoulder).

If **Figure 13** doesn't do it for you, maybe this last one will.

Taking what we've learned thus far, what price for imatinib from Quallent at Express Scripts pharmacies should we expect in 2023? Is it $103 per pill as **Figure 6**'s Medicare experience tells us, the $182 per pill as **Figure 12**'s commercial experience tells us? Or perhaps it is $2.50 as it was for Medicaid in 2024 (**Figure 9**; we looked and there was no Quallent imatinib utilization in Medicaid in 2023 to align the years on). **Figure 14** puts these experiences together for your viewing pleasure.

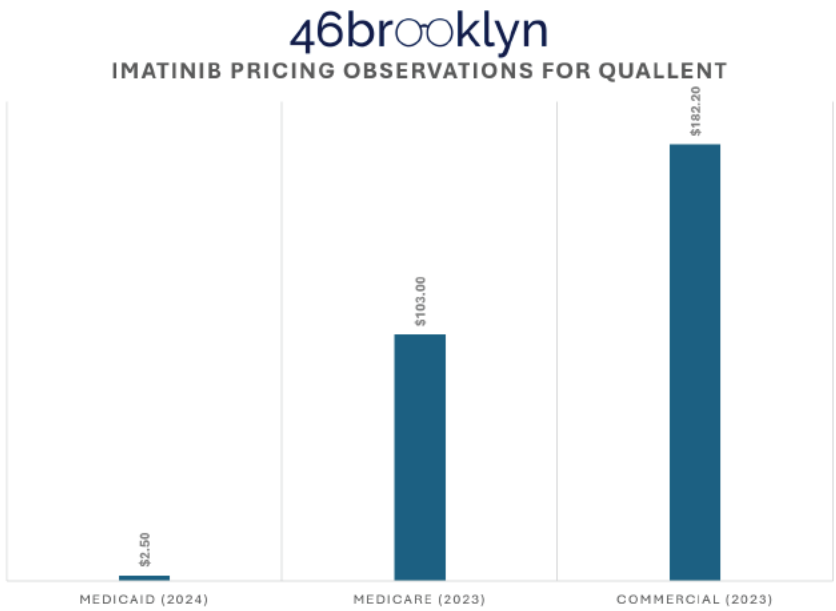

Figure 13

Source: CMS State Drug Utilization Data (2024), Medicare Part D Dashboard (2023), Evernorth NADAC Reports (WV, 2023)

If you're looking at these prices like we are, you start to question how this can be. When the same highly-leveraged company essentially has maximum control over the distribution of a product from drug company to PBM to pharmacy – or more plainly, from price creator to price negotiator to price receiver – how in the world can this range be so pronounced?

And even putting the Medicaid price aside, since the 2024 year doesn't align with Medicare and Commercial, there is a $79 per pill difference between the Medicare and Commercial experience in 2023. Said differently, and to West Virginia employers, would you like to pay a 77% premium relative to Medicare's price for imatinib?

We honestly don't know what price Quallent and/or Express Scripts wants us to expect, because even these averages conceal individual results, which vary widely. It certainly seems that the data is informing us that we've unearthed some sort of hybrid pricing schedule for Express Scripts

specific imatinib prices are different than the $2.50 Medicaid aggregate shown in **Figure 9** (as also demonstrated for lisinopril pricing in **Figures 10 and 11**), and there are commercial West Virginia claims that pay above and below the $182.20 per pill average shown in **Figure 12**.

Perhaps rather than trying to speculate on why things are the way we observe them, we would be better to speculate on what the impact of these observations may be in our drug pricing theme park. We can see a world where, in response to state legislative actions like those of anti-steering to specific mail or specialty pharmacies (see our Accredo/Dell example earlier in this report), the industry moves in a direction that says you can get your imatinib or capecitabine or whatever product you want filled at the pharmacy of your choosing, but the only catch is that the PBM can impose is a labeler restriction that says the dispensed product must be Quallent (i.e., Labeler code 82009). Again, we know labeler code restrictions already exist (see our Medicaid example earlier). The only difference with this new approach is that when the labeler restriction is applied, it might also carry with it the net effect that the PBM-affiliated pharmacy is the only one who can supply the product (only one theme park you can visit to see dinosaurs).

And as the data suggests, this form of steering can yield a wide range of potential impacts to the pharmacy market — some of which can leave non-PBM-affiliated pharmacies filling a disproportionately high number of claims that are less profitable than others and others that can provide a disproportionately high number of highly profitable claims to PBM-affiliated pharmacies. Similarly, this form of steering can yield a wide range of potential impacts to the plans to the end payer — some of which can decrease costs and others that can increase them.

“Life, uh, finds a way.”

Look, we get it, drug pricing is complicated, and we just ran through a lot of numbers really quickly. This started as an educational exercise in how PBMs' private label product strategy may help them skirt anti-steering laws, and we ended up using data to demonstrate that PBMs' role as drug manufacturer might see them adopt the very strategies they claim to advocate against (i.e. inflating drug prices). From an outsider's perspective, we can see how this can seem to be an anti-PBM story, though we honestly do not intend it as such (it's all the plan sponsor's fault, right guys?). Rather, we believe that if you claim to be the only entity working to lower prices – as PBMs do – then you are self-selecting a higher level of scrutiny of your practices relative to other supply chain members.

We acknowledged that we should not be surprised by our findings, as these for-profit companies undoubtedly want to make more money just like every other member of the drug channel, but we guess that the collective hope is that PBMs would find a way to make more money in a manner that is not tied to the price of the medications they're charged with managing (that in some sort of utopia, they might make more money by making us healthier rather than raising our drug premiums because we're sicker than they thought we'd be or burying their compensation underneath the inflated prices of medicines).

If PBMs truly view themselves as cost-containment specialists – the only ones doing so, per their PR – Quallent's imatinib pricing is hard to reconcile with that mission. As a collective body, Express Scripts – who undoubtedly knows more about drug pricing than these humble researchers and consultants – appears to be having trouble finding a way to lower imatinib's costs, but relative upstart Mark Cuban and

been so fascinated with the cost-plus movement (besides its efforts to better align provider incentives) is that the origin of 46brooklyn's DNA was forged by crazy imatinib prices, and somehow, after seven years of writing about it, legacy PBMs have largely failed where much smaller cost-plus pharmacies like Cuban have succeeded.

Is it a system failure? Is it being done on purpose? Is it all the fault of plan sponsors? Or are these a series of unfortunate accidents that somehow push billions of dollars into the pockets for-profit "cost-savers?"

It strikes us a less than rocket science, but perhaps more than dino-DNA extracting, that if your role is to lower drug prices, then when you control the price (because it is dispensed at your affiliated pharmacy or under your owned private label or under your PBM or under your health plan or some combination of any and all of these), you would have enough information and control to guarantee that your price is the lowest – the lowest to the patient, the lowest to the plan, the lowest to the government, the lowest across the board. Except, that is rarely what we see.

Rather, we see a mix, where sometimes they're lower (sometimes by a lot) and sometimes they're higher (also, sometimes by a lot). And in the grand mix of drug products dispensed, the PBM seems to have a magical coin that ensures that on flips that land heads, they win; and on flips that land tails, others lose. Or to paraphrase Jurassic Park, the PBMs were so preoccupied with whether they could set drug prices, they didn't stop to think about whether they should.

Regardless, here we are, still shouting from the watch-towers that drugs like imatinib are still suffering from disparate pricing and frequent bloated mark-ups. Seven years have passed, and Congress is still on cusp of passing something that won't solve it, the FTC is still investigating something we've already known is happening plain as day, and plan sponsors are still signing contracts that sanction the conflicted price-setting and network-creation that provides the real estate for it all to continue. Yet, the chest-beating over high drug prices persists, as if the details underneath the headlines aren't part of the very structure that props them up in the first place.

Do we even want to solve these problems, or is the kayfabe of forever-attacking a non-specific evil blob of high prices all we really want? Just remember, whatever happens, that's the plan.

PREVIOUS

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The Honorable French Hill
Statement for the Record
House Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives
February 11, 2026

Chairman Griffith, Vice Chair Harshbarger, Ranking Member DeGette, and Members of the Subcommittee, thank you for the opportunity to submit a Statement for the Record. I appreciate the opportunity to offer my insights at today's important hearing, "*Lowering Health Care Costs for All Americans: Examination of the Prescription Drug Supply Chain.*"

Health care in America is broken and unsustainable. Arkansans and Americans know this. Like the Members on this subcommittee, I am angry that health care costs are high and unaffordable. Congress must examine the issue of high drug costs by looking at the prescription drug supply chain. I applaud the Subcommittee for holding today's hearing; it is a step in the right direction.

Throughout my time in Congress, I have worked with my colleagues to address the cost of prescription drugs. According to the Kaiser Family Foundation (KFF), approximately one in five adults say they have not filled a prescription because of cost, and a similar amount report that they instead opted for an over-the-counter alternative due to cost.[1] That is unacceptable.

High prescription drug costs do not happen in a vacuum. Each stakeholder in the prescription drug supply chain plays a role in the financial flow that surrounds prescription drugs. Stakeholders in the prescription drug supply chain include group purchasing organizations (GPOs), generic drug manufacturers, brand drug manufacturers, biopharmaceutical manufacturers, distributors, pharmacy service administrative organizations (PSAOs), health plans, pharmacy benefit managers (PBMs), and pharmacies. Each stakeholder mentioned above plays a different role in the prescription drug supply chain. Some stakeholders are directly involved in the physical flow of prescription drugs, others are involved in the financial flow surrounding prescription drugs, and some are involved in both.

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[1]KFF. Americas' Challenges with Health Care Costs. Published Jan. 29, 2026. https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/#:~:text=The%20cost%20of%20prescription%20drugs,and%20those%20with%20lower%20incomes.

Recently, Congress passed PBM reforms, which will provide transparency to drive down drug costs. I am proud to have voted in support of those PBM reforms. While I am pleased to see Congress holding PBMs accountable, I fear that we have not focused enough on the entire prescription drug supply chain to holistically examine drug pricing. Until we do that, we cannot fully address the pressing issue of high prescription drug costs.

To address prescription drug costs, I encourage my colleagues to examine the roles of GPOs, health plans, and distributors in the prescription drug supply chain. All these stakeholders are involved in the financial flow surrounding the movement of medicine. While distributors do physically move prescription medicines, they and their vertically integrated subsidiaries still play a role in the financial flow surrounding prescription drugs.

GPOs, specifically hospital and health-system GPOs, are heavily consolidated and vertically integrated companies. Collectively, at least 80% of the hospital purchasing market is controlled by three large companies.[2] These companies have vertically integrated by expanding transitional purchasing into data analytics, clinical advisory services, and private-label manufacturing. While there may be benefits to this vertical integration, Congress should still examine it to ensure that GPOs do, in fact, reduce prescription drug costs.

Since the enactment of the Affordable Care Act in 2010, health plans have become increasingly vertically integrated companies. Health plans have extensive vertical business relationships within the prescription drug supply chain, including PBMs, GPOs, manufacturers, wholesale distribution entities, specialty and mail pharmacies, retail pharmacies, long-term care pharmacies, and health care providers. This vertical integration is concerning as it allows health insurers to game the system. For example, a large health plan pays its providers 17 percent more than it pays providers it does not own.[3] A health insurer has been found to pay its own subsidiaries more, which is a signal that it is maximizing profits and gaming the medical loss ratio requirements under the Affordable Care Act. In addition, health plan-owned PBMs are used to capture, rather than pass on, drug manufacturer rebates. That keeps drug prices higher and steers patients toward higher-cost drugs and health plan-owned pharmacies. This type of gaming through vertical integration is one of the reasons health costs and prescription drug costs are so high.

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[2] Fein, A. (2023). The 2023-2024 Economic Report on Pharmaceutical Wholesalers and Specialty Distributors. Drug Channels Institute.

[3] Arnold, David R. Fulton, Brent D. Health Affairs. UnitedHealthcare Pays Optum Providers More than Non-Optum Providers. Published Nove. 2025. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00155.

Distributors are also heavily consolidated and vertically integrated companies. The three largest distributors are heavily consolidated as they distribute approximately 90% of prescription drugs in the United States.[4] Similar to health plans, the big three distributors are vertically integrated, as they encompass manufacturers, retail pharmacies, PSAOs, GPOs, specialty providers, and oncology practices.[5]

Of note, distributors lessen competition in the generic drug space through their buying groups, which are also highly consolidated. Buying groups are partially owned by distributors and large retail pharmacies, which negotiate the purchase prices of generic drugs on behalf of retail pharmacies. The three largest buying groups account for nearly 80% of generic drug purchases in the United States.[6] These buying groups undermine competition from new, lower-priced medicines and may lead to generic drug shortages.[7]

Distributors also use their immense influence to purchase oncology practices[8], including smaller oncology practices that provide an alternative to hospital-based cancer care.[9] By purchasing oncology practices, the distributor that owns said oncology practice becomes the primary distributor for the oncology practice. Distributors could also require their oncology practices to enter into sole-source or prime vendor agreements with the distributor. That would block competition and lock in the oncology practice as customers.[10] This ownership and contractual dynamic introduce incentives for distributors and oncology practices to drive larger profits to distributors. For example, when a large distributor became the primary distributor for an oncology practice that the large distributor has a controlling stake in, the practices in that oncology practice led to larger profits for the large distributor.[11]

I encourage my colleagues to thoroughly examine all stakeholders in the prescription drug supply chain, especially GPOs, health plans, and distributors. Congress must understand vertical integration and then address it. Thank you for your consideration. I stand at the ready to work with the Subcommittee on matters related to prescription drug costs.

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[4] The Commonwealth Fund, "The Impact of Pharmaceutical Wholesalers on U.S. Drug Spending," Elizabeth Seeley, July 20, 2022, https://www.commonwealthfund.org/publications/issue-briefs/2022/jul/impact-pharmaceuticalwholesalers-drug-spending.
[5] https://www.drugchannels.net/2025/02/vertical-integration-redux-how.htmlv
[6] Fein, A. (2023). The 2023-2024 Economic Report on Pharmaceutical Wholesalers and Specialty Distributors. Drug Channels Institute.
[7] https://accessiblemeds.org/resources/press-releases/aam-response-to-ftc-hhs-rfi-on-drug-shortages/
[8] The Wall Street Journal, "Why Drug Distributors Are Buying Cancer Specialists," David Wainer, September 27, 2024, https://www.wsj.com/health/pharma/why-drug-distributors-are-buying-cancer-specialists-0ad12c83.
[9] Ibid.
[10] Ibid.
[11] Drug Channels, "The Battle for Oncology Margin: How Private Equity Enables Vertical Integration by Pharmaceutical Wholesalers (rerun)," Dr. Adam J. Fein, December 14, 2023, https://www.drugchannels.net/2023/12/the-battle-for-oncology-margin-how.html.

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Statement for Hearing on
"Lowering Health Care Costs for All Americans: An Examination of the Prescription Drug Supply Chain"

House Committee on Energy and Commerce
Subcommittee on Health

February 11, 2026

AHIP is the national trade association representing the health insurance industry. AHIP's members provide health care coverage, services, and solutions to more than 200 million Americans through public programs such as Medicare and Medicaid, employer-sponsored insurance, and the individual insurance market.

AHIP is committed to working with the Subcommittee to address the core drivers of health care affordability throughout the entire health care system. Health plans use all the tools at their disposal to help make prescription drugs more affordable, promote safe and effective drug use, and protect patients from unpredictable and high drug costs. Health plans, in partnership with pharmacy benefit managers (PBM), are able to negotiate savings, promote the use of lower-cost generics, and make drugs more affordable for consumers and employers.

However, drugmakers' strategy for the U.S. market is increasingly based on preventing competition and undermining negotiators to keep drug prices high for Americans. AHIP's most recent analysis shows that 24.2 cents of every commercial market premium dollar Americans pay now goes to prescription drug costs.[1]

AHIP's statement for the record focuses on how health plans are taking action to ensure Americans have access to affordable drug coverage and bipartisan reforms Congress can pass to address the high prices of prescription drugs manufacturers set for American patients. We support efforts in Congress to advance common-sense policies that ensure access to treatments and lower drug prices and help make health care more affordable and accessible.

Drugmaker Pricing is Fueling Higher Health Care Costs

As noted, prescription drug costs account for nearly one quarter of commercial health insurance premiums.

[1] https://www.ahip.org/resources/where-does-your-health-care-dollar-go

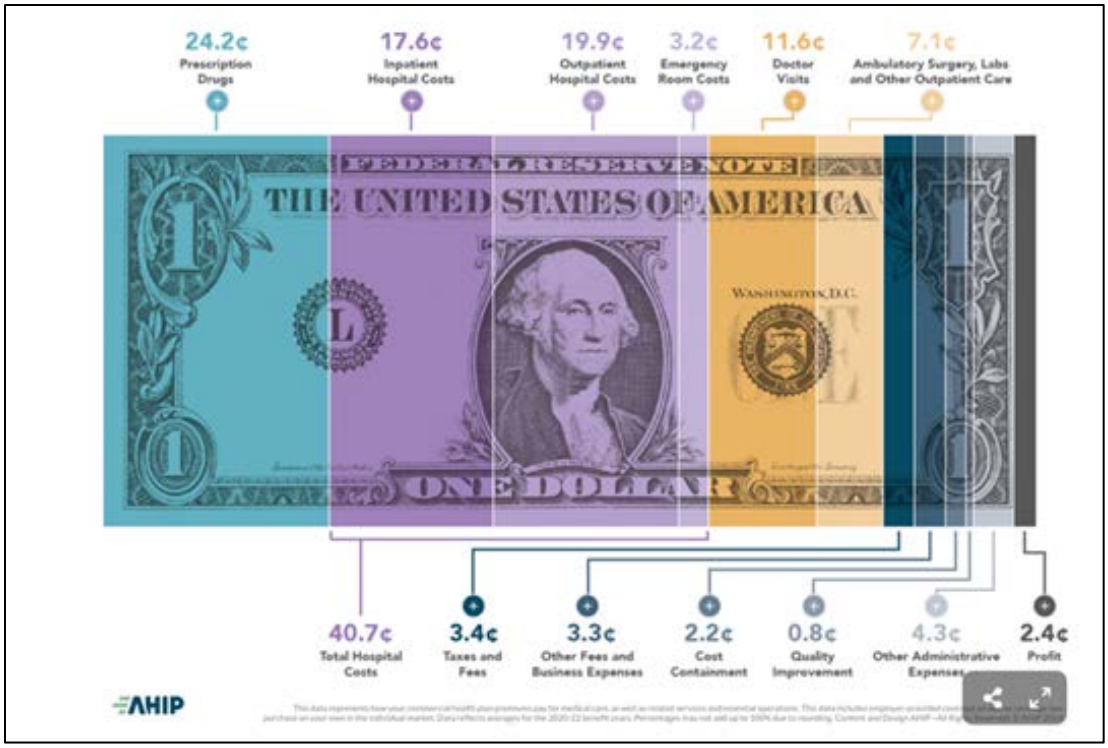

Figure 1: AHIP's Health Care Dollar. The full resource can be accessed at https://www.ahip.org/resources/where-does-your-health-care-dollar-go.

The substantial scale of spending on prescription drugs demonstrates how drug pricing is one of the most significant cost pressures that consumers and employers face, especially as new costly treatments come to market backed by lavishly funded marketing campaigns. Accelerated growth in drug spending is expected to be a key driver of premium growth in 2026, due to rising unit prices, costly new gene and cell therapies, and growing demand for weight-loss medications (GLP-1s).[2]

Drugmakers also often raise prices multiple times a year. In 2026, brand drugmakers have already increased prices on 872 prescription drugs, with a median list-price hike outpacing the rate of inflation, fueling premium increases and higher out-of-pocket costs for patients.[3,4]

Brand-name drug manufacturers also continue to spend heavily on marketing - particularly direct-to-consumer (DTC) advertising - that drives demand for high-priced products. The United States is one of only two countries that permits prescription drug advertising directly to

[2] https://actuary.org/wp-content/uploads/2025/07/brief-Drivers-2026-Premium.pdf
[3] https://www.npr.org/2026/01/14/nx-s1-5669401/many-brand-name-drug-prices-are-going-up-despite-trump-administration-deals
[4] https://www.csrxp.org/csrxp-big-pharma-rings-in-2026-with-more-than-300-price-increases-on-brand-name-drugs-outpacing-start-of-2025/

consumers, and manufacturers now spend tens of billions of dollars annually on advertising and promotion, often during high-profile events and across digital platforms.[5] Just this past Sunday, brand drugmakers spent an estimated $72 million to capture the attention of 125 million Americans during Super Bowl LX, running five ads ranging from 30 seconds to 90 seconds in length that cost $8 million every 30 seconds of air time.[6,7,8] While the Super Bowl attracts global viewership, consumers in nearly all other countries were not subject to these advertisements.

These marketing strategies directly contribute to the high list prices drug manufacturers set, and increase, over time on prescription drugs sold to American patients. Prescription drug costs are unsustainable because drugmakers unilaterally set the list prices for their medications and control subsequent price increases.

How Health Plans and PBM Partners Work to Keep Prescription Drugs Affordable

Health plans work to help families and employers afford prescription drug coverage by negotiating lower prices, promoting competition, and managing benefits in ways that prioritize clinical value and patient access. Health plans' PBM partners use tools such as evidence-based formularies, generic and biosimilar adoption, and medication management programs to encourage patients to choose safe, effective, lower-cost options. Health plans also offer services such as prescription drug home delivery that can lead to higher medication adherence.[9] In practice, these functions can help to counter manufacturers' pricing power and ensure plan sponsors can offer comprehensive drug coverage despite steadily rising prices set by manufacturers.

Congress has enacted PBM reforms intended to strengthen transparency and accountability. Newly enacted provisions from the government funding package include requirements to pass through manufacturer remuneration to payers and increased oversight of pharmacy contract terms.[10] As health plans work with PBMs to operationalize these changes, our focus remains clear: ensure savings flow to lower premiums and out-of-pocket costs and maintain robust pharmacy access for patients.

As Congress continues to examine ways to address the affordability crisis affecting millions of Americans, AHIP urges the Subcommittee to take an essential, common-sense step toward tackling a root cause of rising health care costs: curbing inflationary and often anti-competitive drug pricing practices employed by drug manufacturers.

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[5] https://www.tandfonline.com/doi/abs/10.1080/02650487.2004.11072880
[6] https://www.mmm-online.com/news/how-super-bowl-60-became-the-pharma-bowl/
[7] https://www.usatoday.com/story/sports/nfl/super-bowl/2026/02/08/how-much-does-super-bowl-commercial-cost-2026/88510663007/
[8] https://www.nielsen.com/news-center/2026/super-bowl-lx-delivers-124-9-million-viewers/
[9] https://pmc ncbi nlm nih.gov/articles/PMC10397763/
[10] https://www.congress.gov/bill/119th-congress/house-bill/7148

Factors Driving Higher Drug Costs and Drugmaker Profits

Drug prices are rising as a direct result of manufacturer decisions that limit competition, set ever-higher launch prices, and allow repeated price increases over time. Together, these dynamics are driving unsustainable drug spending and massive profits for manufacturers, while exacerbating affordability for patients, employers, and the entire health care system.

- **Manufacturer Control and Anticompetitive Practices:** Practices like patent thicketing - when a drug manufacturer files dozens or hundreds of patents on a single medication - and product hopping - when a manufacturer makes a small tweak to an existing drug just before a patent expires - extend monopolies and block competition from generics and biosimilars, keeping prices high.

- **Costly New Therapies and Demand Surges:** Gene and cell therapies, while groundbreaking, come with price tags that can exceed $1 million per patient. In addition, demand for GLP-1 weight-loss drugs is skyrocketing, adding billions to overall spending.

- **Outsized Spending Impact of Specialty Drugs:** Brand-name specialty drugs and biologics, used for treating complex or rare diseases, and often costing tens of thousands of dollars or more for a course of treatment, now account for more than 51 percent of total spending, despite comprising only 5 percent of prescriptions in the United States.[11]

- **Record Profits for Drugmakers:** Pharmaceutical manufacturers average annual margins of 23.2 percent.[12] In comparison, health plans operate under strict federal caps on profits and administrative costs – spending at least 80–85 percent of premiums on medical care. According to the National Association of Insurance Commissioners, health plans' profit margins were 0.8 percent in 2024.[13]

Bipartisan Solutions to Improve Patient Affordability

Although new and innovative medications and treatments can offer important health benefits, patients should be able to access them at costs they can afford – without spiking their premiums. Nevertheless, health plans continue to do everything in their power to shield consumers from exorbitant prescription drug prices. Innovative solutions that health plans have developed to make prescription drugs more affordable include leveraging lower-cost specialty pharmacies to

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[11] https://aspe hhs.gov/sites/default/files/documents/88c547c976e915fc31fe2c6903ac0bc9/sdp-trends-prescription-drug-spending.pdf

[12] https://www.csrxp.org/csrxp-analysis-pharmaceutical-industrys-profit-margins-still-10-times-greater-than-other-sectors-of-drug-supply-chain/

[13] https://content.naic.org/sites/default/files/2024-annual-health-industry-commentary.pdf

safely distribute physician-administered drugs, capping out-of-pocket copays on prescription drugs, and providing fully transparent price models.[14]

However, Congress is needed to rein in drugmaker's anticompetitive practices that prevent competition, undermine negotiators and ultimately, keep drug prices as high as possible for Americans. When competition exists, health plans – in partnership with PBMs – can negotiate savings, promote the use of lower-cost generics, and make drugs more affordable for consumers. To that end, AHIP urges timely bipartisan action to protect American consumers, employers, and taxpayers from the rising prices of prescription drugs set by manufacturers.

The key tenets of policy approaches that Congress should advance include:

- **Boosting Competition:** Cultivating innovation means generating competition for products once initial patents have expired. Drug manufacturers should invest in new treatments rather than perpetuating existing patent monopolies on older drugs. AHIP urges Congress to support legislation that curbs patent abuses, saving taxpayers billions of dollars.[15]
- **Increasing Transparency:** To save money for all patients, health plans need tools to encourage manufacturers to compete on price, not on relentless marketing campaigns and cash subsidies for patients and physicians. Congress should require the clear disclosure of manufacturers' pricing practices and rebate flows, so consumers understand what they're paying for.[16]
- **Make Generics and Biosimilars Easier and Cheaper:** Biologic medicines have changed health care and improved patient outcomes, and the first generation of biologics have become eligible for generic-style competition from biosimilars. But outdated approval requirements and red tape on substitutions mean patients are not seeing lower prices. AHIP urges Congress to crack down on anticompetitive behavior that blocks generics and biosimilars from entering the market, giving patients more affordable options.[17]

Legislative Opportunities for the Committee

The Committee specifically can build on momentum for market-based solutions to make drug prices more affordable. A policy success story is the recent reformation of Q1/Q2 sameness requirements, the clarification and codification of the Food and Drug Administration's (FDA) authority to disclose information on how generic drugs can be qualitatively and quantitatively the same as brand-name drugs, allowing for a more efficient generics approval process. The bill was

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[15] https://www.ahip.org/resources/stop-patent-abuse
[16] https://www.ahip.org/resources/make-manufacturers-compete-on-price-not-cash-subsidies
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first advanced unanimously by the full Energy and Commerce Committee, passed Congress with bipartisan support, and was signed into law by President Trump on February 3, 2026.[18]

AHIP applauds Energy and Commerce for its leadership in advancing common-sense, bipartisan reforms such as Q1/Q2 sameness requirements and urges the Committee to take further action to protect Americans from the rising prices of prescription drugs set by manufacturers. Other policy solutions within the jurisdiction of the Committee include:

H.R. 3789, the Drug-price Transparency for Consumers (DTC) Act

- Congress should pass this bipartisan legislation requiring pharmaceutical manufacturers to disclose list prices in direct-to-consumer advertising and help patients make more informed, value-based health care decisions. DTC ads can drive demand for high-cost brand-name drugs without meaningful information about alternatives or affordability, contributing to higher spending and increased pressure on premiums and out-of-pocket costs.[19] This common-sense reform, which was also proposed by the Trump Administration in 2018, would complement efforts to lower drug costs, promote a more competitive marketplace, and put patients and affordability first.

H.R. 5526, the Biosimilar Red Tape Elimination Act

- This bipartisan legislation would remove the statutory distinction between biosimilars and interchangeable biosimilars, improving patient access and reducing health care costs. Since 2015, biosimilars have delivered over $56 billion in savings and supported more than 3.3 billion days of patient therapy with no clinically meaningful differences in safety or outcomes.[20] This bipartisan bill would strengthen confidence in biosimilars and streamline patient access.

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- AHIP urges Congress to consider policies that would require drugmakers to publicly justify high prices and report pricing information on drug manufacturing and research and development costs, net profits, and marketing and advertising costs for expensive medications. To this end, the Committee should advance policies from this legislation, previously introduced in the 118th Congress, to apply basic transparency to drug pricing and require drug manufacturers to justify their price increases.

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[19] https://www.cbo.gov/publication/60812
[20] https://accessiblemeds.org/wp-content/uploads/2026/01/Group-Support-Letter_Advance-BRTEA_012126.pdf

More broadly, AHIP urges Congress to pass legislation under the jurisdiction of additional Committees that address the drivers of increasing drug costs. These include:

Affordable Prescriptions for Patients Act

- This bipartisan legislation, advanced by unanimous consent in the Senate in the 118th Congress, would boost competition by limiting manufacturers' ability to manipulate the patent litigation process by placing a limit on the number of patents a manufacturer can contest, preventing patent thicketing.

Interagency Patent Coordination and Improvement Act

- This bill would establish a cooperative task force between the U.S. Patent and Trademark Office (USPTO) and the FDA in order for the two agencies to be more collaborative in their patent-related functions. This legislation would create a more competitive drug market and lower costs for consumers.

Preserve Access to Affordable Generics and Biosimilars Act

- By restraining anticompetitive "pay-for-delay" deals that delay and prevent the introduction of more affordable follow-on developments and generic versions of branded drugs, this legislation would reduce the cost of drugs and reduce the growing cost burden on patients and our health care system.

Conclusion

AHIP thanks the Subcommittee for the opportunity to comment on policies that seek to lower the prices of prescription drugs for Americans. As Congress considers these important issues, AHIP appreciates the Subcommittee's focus on improving affordability while preserving access to high-quality care. AHIP looks forward to continuing to work collaboratively with the Subcommittee to identify and implement common-sense, market-based policy solutions that make the health care system more affordable for patients and families and more sustainable for the country over the long-term.

February 11, 2026

The Honorable Morgan Griffith
Chairman, Health Subcommittee
House Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Diana DeGette
Ranking Member, Health Subcommittee
House Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Griffith and Ranking Member DeGette:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,300 family physicians and medical students across the country, I write to thank you for holding today's hearing titled "Lowering Health Care Costs for All Americans: An Examination of the Prescription Drug Supply Chain."

The AAFP maintains that the family physician is the patient's advocate. That advocacy demands that the family physician prescribe safe, efficacious pharmaceutical products to deliver high quality medical care, with sensitivity to the patient's individual medical and financial circumstances. About six in ten adults report currently taking at least one prescription drug, and a quarter report taking four or more prescriptions.[i] However, the overwhelming majority of adults (82 percent) find the cost of prescription drugs to be unreasonable and more than half (55 percent) worry about being able to afford their family's medications.[ii] Thus, advocating to lower the exorbitant cost of prescription drugs on behalf of their patients is a salient issue for family physicians.

The Academy finds it deeply troubling that significant shares of patients report not adhering to their physician's recommended course of medication treatment because of cost. Specifically, about one in five adults say they have not filled a prescription and 12 percent say they have rationed their medication (i.e. cut pills in half or skipped a dose).

Across all drugs, U.S. gross drug prices were 278 percent of other countries' prices and 422 percent for brand name originator drugs. Even with the application of manufacturer-paid rebates, U.S. net prices for brand name drugs were three times higher than in other countries.[iii] It is telling that, while most Americans worry about affording their medications, U.S.-based executives for pharmaceutical companies continue to top the list for overall industry compensation. David Ricks – the CEO for Eli Lilly and the industry's second highest paid executive – has seen his compensation balloon from $15.8 million in 2017 to nearly double ($29.2 million) in 2024. Pfizer CEO Albert Boula saw a 14 percent increase in his compensation from 2023 to 2024, spiking at $24.6 million. And Amgen's CEO Robert Bradway rounded out the industry's top four highest paid executives in 2024 with a compensation package of $24.4 million.

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We want to be clear and say that the invaluable work spearheaded by these companies and their executives deserves to be financially recognized. The prescription drugs and other pharmaceutical products they invest in and bring to market are lifechanging and, often, lifesaving. Polling shows that public opinion reflects this, with 63 percent of adults believing prescription drugs developed over the last two decades have generally made our lives better.[iv] Capital investments are necessary to support the research and development of these products and to incentivize further innovation. However, if the price tag associated with a medication leaves it out of reach of those who need it, what's the point of developing them in the first place?

We hope that the Subcommittee will thoroughly examine this issue during today's hearing and explore opportunities to advance policies that will meaningfully improve access to medications for those who need them, including by addressing financial barriers. The AAFP supports legislation ensuring the availability of effective, safe and affordable medications through policies that support governmental authority to promote competition and availability, transparency, patient-centric pricing, drug price negotiation and review. To advance these goals, the Subcommittee should consider legislation to prohibit abuses of the U.S. patent system, such as pay-for-delay and patent thicket practices, and require drug manufacturers to report to the Department of Health and Human Services information and supporting documentation to justify price increases for drugs and biological products.

Further, the Academy supports full disclosure to physicians and patients of corporate ties and financial relationships between pharmaceutical manufacturers, mail order pharmacies, pharmacy benefit management entities and pharmacists. Additionally, formulary decisions and "drug switching" should not be based principally on financial considerations, but on evidence-based therapeutic and quality of care considerations, to promote optimal patient care.

Thank you for convening today's hearing to examine the issues within our nation's prescription drug supply chain. The AAFP looks forward to partnering with you to implement reforms that will ensure all patients have access to the medications that they need without financial barriers. Should you have any additional questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,

Jon Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

[i] Sparks, G., Kirzinger, A., Montero, A., Valdes, I., & Hamel, L. (2024, October 4). *Public Opinion on Prescription Drugs and Their Prices*. KFF. https://www.kff.org/health-costs/public-opinion-on-prescription-drugs-and-their-prices/.

[ii] Ibid.

[iii] Mulcahy, A. W., Schwam, D., & Lovejoy, S. L. (2024). *International Prescription Drug Price Comparisons: Estimates Using 2022 Data* (Research Report RR-A788-3). RAND Corporation.

[iv] Kansteiner, F., Becker, Z., Sagonowsky, E., Liu, A., & Dunleavy, K. (2025, June 16). *Big Pharma's 10 highest-paid CEOs of 2024*. FiercePharma. https://www.fiercepharma.com/special-reports/big-pharmas-10-highest-paid-ceos-2024.

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Statement for Hearing on
"Lowering Health Care Costs for All Americans: An Examination of the Prescription Drug Supply Chain"

House Committee on Energy and Commerce
Subcommittee on Health

February 11, 2026

AHIP is the national trade association representing the health insurance industry. AHIP's members provide health care coverage, services, and solutions to more than 200 million Americans through public programs such as Medicare and Medicaid, employer-sponsored insurance, and the individual insurance market.

AHIP is committed to working with the Subcommittee to address the core drivers of health care affordability throughout the entire health care system. Health plans use all the tools at their disposal to help make prescription drugs more affordable, promote safe and effective drug use, and protect patients from unpredictable and high drug costs. Health plans, in partnership with pharmacy benefit managers (PBM), are able to negotiate savings, promote the use of lower-cost generics, and make drugs more affordable for consumers and employers.

However, drugmakers' strategy for the U.S. market is increasingly based on preventing competition and undermining negotiators to keep drug prices high for Americans. AHIP's most recent analysis shows that 24.2 cents of every commercial market premium dollar Americans pay now goes to prescription drug costs.[1]

AHIP's statement for the record focuses on how health plans are taking action to ensure Americans have access to affordable drug coverage and bipartisan reforms Congress can pass to address the high prices of prescription drugs manufacturers set for American patients. We support efforts in Congress to advance common-sense policies that ensure access to treatments and lower drug prices and help make health care more affordable and accessible.

Drugmaker Pricing is Fueling Higher Health Care Costs

As noted, prescription drug costs account for nearly one quarter of commercial health insurance premiums.

[1] https://www.ahip.org/resources/where-does-your-health-care-dollar-go

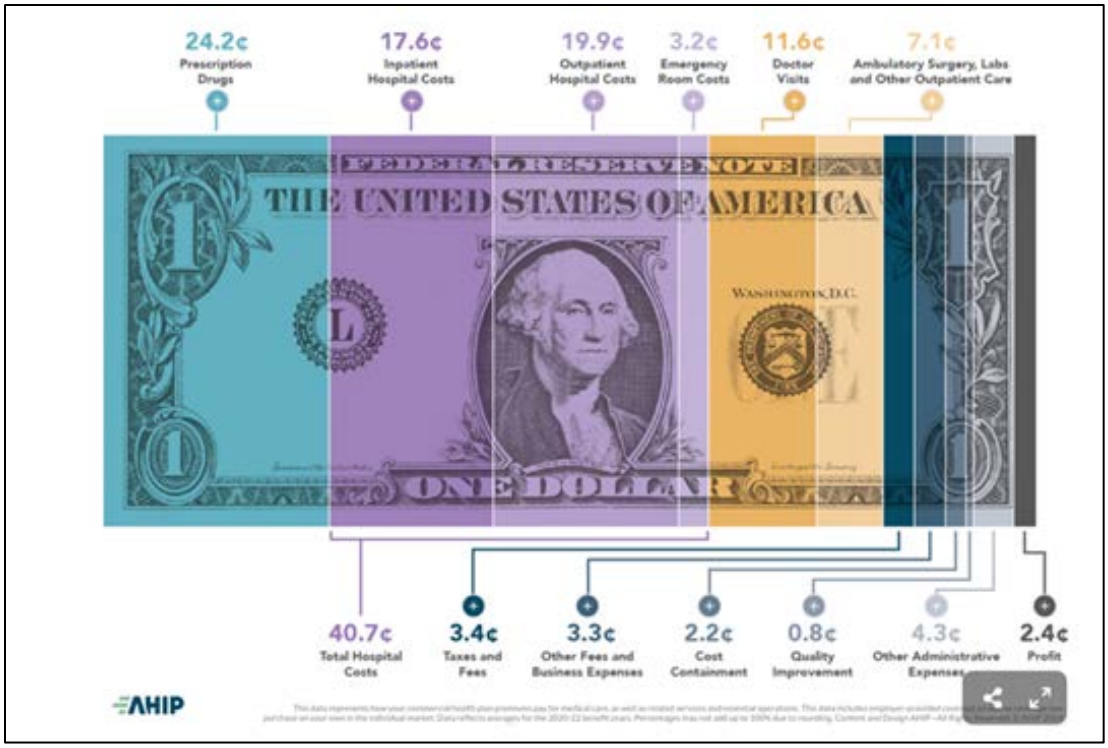

Figure 1: AHIP's Health Care Dollar. The full resource can be accessed at https://www.ahip.org/resources/where-does-your-health-care-dollar-go.

The substantial scale of spending on prescription drugs demonstrates how drug pricing is one of the most significant cost pressures that consumers and employers face, especially as new costly treatments come to market backed by lavishly funded marketing campaigns. Accelerated growth in drug spending is expected to be a key driver of premium growth in 2026, due to rising unit prices, costly new gene and cell therapies, and growing demand for weight-loss medications (GLP-1s).[2]

Drugmakers also often raise prices multiple times a year. In 2026, brand drugmakers have already increased prices on 872 prescription drugs, with a median list-price hike outpacing the rate of inflation, fueling premium increases and higher out-of-pocket costs for patients.[3,4]

Brand-name drug manufacturers also continue to spend heavily on marketing - particularly direct-to-consumer (DTC) advertising - that drives demand for high-priced products. The United States is one of only two countries that permits prescription drug advertising directly to

[2] https://actuary.org/wp-content/uploads/2025/07/brief-Drivers-2026-Premium.pdf
[3] https://www.npr.org/2026/01/14/nx-s1-5669401/many-brand-name-drug-prices-are-going-up-despite-trump-administration-deals
[4] https://www.csrxp.org/csrxp-big-pharma-rings-in-2026-with-more-than-300-price-increases-on-brand-name-drugs-outpacing-start-of-2025/

consumers, and manufacturers now spend tens of billions of dollars annually on advertising and promotion, often during high-profile events and across digital platforms.[5] Just this past Sunday, brand drugmakers spent an estimated $72 million to capture the attention of 125 million Americans during Super Bowl LX, running five ads ranging from 30 seconds to 90 seconds in length that cost $8 million every 30 seconds of air time.[6,7,8] While the Super Bowl attracts global viewership, consumers in nearly all other countries were not subject to these advertisements.

These marketing strategies directly contribute to the high list prices drug manufacturers set, and increase, over time on prescription drugs sold to American patients. Prescription drug costs are unsustainable because drugmakers unilaterally set the list prices for their medications and control subsequent price increases.

How Health Plans and PBM Partners Work to Keep Prescription Drugs Affordable

Health plans work to help families and employers afford prescription drug coverage by negotiating lower prices, promoting competition, and managing benefits in ways that prioritize clinical value and patient access. Health plans' PBM partners use tools such as evidence-based formularies, generic and biosimilar adoption, and medication management programs to encourage patients to choose safe, effective, lower-cost options. Health plans also offer services such as prescription drug home delivery that can lead to higher medication adherence.[9] In practice, these functions can help to counter manufacturers' pricing power and ensure plan sponsors can offer comprehensive drug coverage despite steadily rising prices set by manufacturers.

Congress has enacted PBM reforms intended to strengthen transparency and accountability. Newly enacted provisions from the government funding package include requirements to pass through manufacturer remuneration to payers and increased oversight of pharmacy contract terms.[10] As health plans work with PBMs to operationalize these changes, our focus remains clear: ensure savings flow to lower premiums and out-of-pocket costs and maintain robust pharmacy access for patients.

As Congress continues to examine ways to address the affordability crisis affecting millions of Americans, AHIP urges the Subcommittee to take an essential, common-sense step toward tackling a root cause of rising health care costs: curbing inflationary and often anti-competitive drug pricing practices employed by drug manufacturers.

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[5] https://www.tandfonline.com/doi/abs/10.1080/02650487.2004.11072880
[6] https://www.mmm-online.com/news/how-super-bowl-60-became-the-pharma-bowl/
[7] https://www.usatoday.com/story/sports/nfl/super-bowl/2026/02/08/how-much-does-super-bowl-commercial-cost-2026/88510663007/
[8] https://www.nielsen.com/news-center/2026/super-bowl-lx-delivers-124-9-million-viewers/
[9] https://pmc ncbi nlm nih.gov/articles/PMC10397763/
[10] https://www.congress.gov/bill/119th-congress/house-bill/7148

Factors Driving Higher Drug Costs and Drugmaker Profits

Drug prices are rising as a direct result of manufacturer decisions that limit competition, set ever-higher launch prices, and allow repeated price increases over time. Together, these dynamics are driving unsustainable drug spending and massive profits for manufacturers, while exacerbating affordability for patients, employers, and the entire health care system.

- **Manufacturer Control and Anticompetitive Practices:** Practices like patent thicketing - when a drug manufacturer files dozens or hundreds of patents on a single medication - and product hopping - when a manufacturer makes a small tweak to an existing drug just before a patent expires - extend monopolies and block competition from generics and biosimilars, keeping prices high.

- **Costly New Therapies and Demand Surges:** Gene and cell therapies, while groundbreaking, come with price tags that can exceed $1 million per patient. In addition, demand for GLP-1 weight-loss drugs is skyrocketing, adding billions to overall spending.

- **Outsized Spending Impact of Specialty Drugs:** Brand-name specialty drugs and biologics, used for treating complex or rare diseases, and often costing tens of thousands of dollars or more for a course of treatment, now account for more than 51 percent of total spending, despite comprising only 5 percent of prescriptions in the United States.[11]

- **Record Profits for Drugmakers:** Pharmaceutical manufacturers average annual margins of 23.2 percent.[12] In comparison, health plans operate under strict federal caps on profits and administrative costs – spending at least 80–85 percent of premiums on medical care. According to the National Association of Insurance Commissioners, health plans' profit margins were 0.8 percent in 2024.[13]

Bipartisan Solutions to Improve Patient Affordability

Although new and innovative medications and treatments can offer important health benefits, patients should be able to access them at costs they can afford – without spiking their premiums. Nevertheless, health plans continue to do everything in their power to shield consumers from exorbitant prescription drug prices. Innovative solutions that health plans have developed to make prescription drugs more affordable include leveraging lower-cost specialty pharmacies to

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AARP
STATEMENT FOR THE RECORD
for the

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
on

LOWERING HEALTH CARE COSTS FOR ALL AMERICANS: AN EXAMINATION OF THE PRESCRIPTION DRUG SUPPLY CHAIN

February 11, 2026
Washington, DC

For further information contact:
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AARP appreciates the opportunity to submit this statement for the record and commends the Subcommittee for holding today's important hearing, *Lowering Health Care Costs for All Americans: An Examination of the Prescription Drug Supply Chain*. We applaud the Subcommittee's bipartisan commitment to examining the root drivers of prescription drug costs and the safety and stability of the drug supply chain. Health care affordability remains a serious challenge for too many families across the country. Recent steps to lower drug prices, including Medicare negotiation and capping out-of-pocket costs in Part D, are already helping millions of seniors better afford the medications they depend on. At the same time, persistent and worsening shortages of essential medicines underscore the growing instability of the drug supply chain and deep vulnerabilities that cannot be ignored. We value the Subcommittee's attention to these issues and today's focus on ensuring that critical medications – like blood pressure drugs, statins, and cancer treatments – remain safe, accessible, and affordable for older Americans.

Improving Reliability of the Supply Chain and Eliminating Drug Shortages

Supply chain-related drug shortages can delay or deny necessary care, sometimes forcing providers to use less effective alternatives. This is especially concerning for older adults: research indicates that almost three-quarters of those impacted by drug shortages were consumers ages 45 to 85. For seniors managing chronic health conditions, even short disruptions can have serious consequences for health, independence, and peace of mind. Therefore, a reliable medication supply is not just important but often life-sustaining. When drug shortages occur, there are very few policy options that can immediately fix the problem. Instead, we should proactively study, prepare for, and avoid supply chain disruptions before they become a crisis.

AARP recognizes that drug shortages are driven by complex and multifaceted causes that will need broad, long-term solutions. For example, we support the Administration's August 13, 2025, Executive Order to create a strategic reserve of active pharmaceutical ingredients (APIs) essential to national health and security, with an emphasis on domestic sourcing. Having an API stockpile will help ensure that domestic manufacturers and compounders have access to vital ingredients during shortages or disruptions.

We also support the bipartisan *Mapping America's Pharmaceutical Supply (MAPS) Act* (H.R. 4191), which would require the Department of Health and Human Services to work with federal agencies and the private sector to map the full supply chain for selected essential medicines. A comprehensive approach is critical to detecting and preventing supply disruptions, ultimately ensuring that patients maintain access to necessary medications.

Improving Affordability and Access

When supply chains are not operating with stability and effectiveness, the consequences go beyond drug shortages – they also lead to higher prices, delayed treatments, and increased financial strain on older adults and their families. High and rising drug prices force impossible tradeoffs: skipping doses, delaying care, or sacrificing basic needs. With older Americans relying on prescription drugs more than any other population – often 4-5 medications per month – this is not a theoretical problem: it is a daily reality for millions of Medicare beneficiaries.

The Root Problem: Drug Prices Start High – and Keep Rising

While Medicare-negotiated drug prices are finally starting to bring savings to older Americans, most prescription drugs are still outside of the negotiation program. Among these non-negotiated drugs, recent evidence shows that brand name drugs often enter the market at very high prices and then increase sharply over time. The median price of a new brand-name prescription drug is now more than $370,000 per year. According to a January 2026 AARP Public Policy Institute analysis, list prices for 25 top Medicare Part B and Part D drugs have increased an average of 67% after entering the market. These lifetime price increases often exceed inflation, ranging from 0 percent to 244 percent. For example, the price of Orencia, a medication used to treat psoriatic and rheumatoid arthritis, has increased 244 percent since entering the market in 2005. The price of Trulicity, which is used to treat type 2 diabetes, has increased 102 percent since entering the market in 2014.

The analysis also found that on average, one-third of the current list prices for these drugs is attributable solely to post-launch price increases. This confirms that many of today's highest-cost Medicare drugs are expensive not because they are new, but because manufacturers have repeatedly raised prices year after year. Higher Medicare spending driven by high and growing non-negotiated drug prices will affect all Americans in the form of higher taxes, cuts to the Medicare program, or both.

Accountability Across the Supply Chain

Affordability requires accountability throughout the prescription drug supply chain. AARP strongly supports bipartisan, comprehensive reform that addresses problematic business practices in the drug supply chain that contribute to a system where patients – especially older Americans on fixed incomes – struggle to access or afford the medications they need.

We also thank the Subcommittee and Congress for their work to improve transparency and accountability in pharmacy benefit manager (PBM) practices, including recently enacted reforms in the *Consolidated Appropriations Act, 2026* to delink PBM compensation from drug prices in Medicare Part D and increase transparency in reporting. PBMs were originally designed to negotiate lower drug prices and manage pharmacy benefits. However, there are concerns that some of their business practices are no longer serving consumers. Such business practices are contrary to PBMs' intended purpose and should not be allowed to continue. These new policies are important complements to drug manufacturer-focused reforms and make a meaningful step toward a more transparent and affordable prescription drug system for older Americans and their families.

Medicare Negotiation and Inflation Protections

For the first time, many older Americans are seeing their prescription drug costs go down instead of up. Medicare-negotiated prices are already lowering what people pay at the pharmacy counter, offering real relief to seniors who have struggled with high prices for decades. The new out-of-pocket cap in Part D is also giving families something they've long needed: predictability. Instead of facing thousands of dollars in unexpected costs, older adults now know their annual

expenses will not exceed a set limit. These changes mean that older adults can finally budget for their medications without fear of unaffordable bills or sudden price spikes.

Recent data on lifetime price increases highlight the importance of the 2022 prescription drug law's targeted and data-driven provisions that allow Medicare to negotiate lower drug prices and require drug companies to pay penalties when they increase their prices faster than the rate of inflation. Therefore, the pharmaceutical industry's attempts to weaken and delay these policies based on unproven concerns about innovation only seek to serve themselves, and risk adding billions in unjustified taxpayer spending and undermining much-needed savings for older Americans.

As the Subcommittee continues its work on prescription drug policy, on behalf of 125 million Americans age 50 and older and their families, AARP urges you to maintain momentum on lowering drug prices. These reforms are making a real difference in people's lives and we encourage Congress to protect and build on this progress to deliver further relief to older Americans across the country.

Competition Matters When It's Allowed to Work

There is overwhelming evidence that meaningful price competition – especially through timely generic and biosimilar entry – is essential to lowering drug prices, and AARP strongly supports efforts to ensure this competition is not unnecessarily delayed.

AARP has long maintained that every person should have reliable access to high-quality, affordable prescription drugs. Older Americans need relief they can feel at the pharmacy counter. We thank the Subcommittee for the opportunity to share our perspective and stand ready to work with you to advance legislation that further reduces prescription drug prices, strengthens the pharmaceutical supply chain and ensures that medications remain affordable and accessible to families across the country.

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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

Health Subcommittee

of the

United States House of Representatives

"Lowering Health Care Costs for All Americans: An Examination of the Prescription Drug Supply Chain"

February 11, 2026

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, as well our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — the American Hospital Association (AHA) appreciates the opportunity to provide the hospital field's perspective on the impact that high and rising drug prices, as well as other drug supply chain inefficiencies, have on their ability to care for patients and communities nationwide.

For decades, the blue and white "H" symbol has been a beacon of healing, hope and health across the country. America's hospitals and health systems take deep pride in the role they serve as the only source of constant, around-the-clock, high acuity care, and they remain unwavering in their commitment to delivering safe and quality care to every patient, in every community. Hospitals and health systems rely on a durable and efficient drug supply chain to achieve these goals and ensure patients have access to the medications they need. As one of the largest acquirers of pharmaceuticals in the country, hospitals and health systems are directly impacted by drug supply chain inefficiencies, including high prices.

Hospitals and health systems share the committee's concern with the problems in the drug supply chain that have increased health care costs for Americans and threatened access to life-saving therapies. Hospitals and health systems have supported efforts that lower drug prices, bring needed transparency to the drug industry's pricing decisions, and foster a durable drug supply chain.

The following statement highlights the concerns of hospitals and health systems, as well as potential solutions the committee could consider in its effort to bolster the drug supply chain and curb drug costs to promote stable access to more affordable health care for all Americans.

DRUG PRICES AND HOSPITAL CARE

Drug prices in the U.S. are among the highest in the world and continue to grow at an unsustainable pace. The average launch price of a new drug in 2024 was $370,000, a 23% increase from the prior year,[1] and the prices for many drugs increase every year, often faster than inflation. A recent report highlights that in 2025, 688 drugs — many used to treat conditions like cancer, depression and asthma — experienced price increases above general inflation, with several drugs more than doubling in price.[2] More recently, a report found that nearly 900 drugs experienced drug price increases in just the first two weeks of 2026.[3]

Many of the drugs experiencing price increases or being introduced at high prices are primarily used by hospitals, significantly increasing hospitals' costs to care for patients. Examples include *Lenmeldy* (used to treat pediatric metachromatic leukodystrophy) and *Tecelra* (used to treat synovial sarcoma), which cost $4.25 million and $727,000, respectively. In 2024 alone, hospitals and health systems spent approximately $144 billion to acquire drugs needed for patient care.[4] This amounted to, on average, approximately 10% of a hospital's annual budget.[5] At the same time, hospitals are required to spend scarce resources to deal with instability and other problems in the drug supply chain. These include implementing workarounds to address drug shortages and other supply chain issues, adjusting purchasing in response to changing tariffs, and managing evolving drug manufacturer restrictions on accessing 340B discounts all add considerable staffing, technology and supplemental drug purchasing costs.

In addition, drug and pharmacy expenses are one of the most variable and hard to predict aspects of hospitals' budgets. Despite being major purchasers, hospitals, like many other providers, are often "price-takers" with little ability to address drug costs.

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[1] https://www.reuters.com/business/healthcare-pharmaceuticals/prices-new-us-drugs-doubled-4-years-focus-rare-disease-grows-2025-05-22/
[2] https://www.sanders.senate.gov/wp-content/uploads/9.29.25-HELP-Minority-Report-Trump-Drug-Price-Increases.pdf
[3] https://www.pharmexec.com/view/companies-raise-list-prices-16-agreements-lower-prices-trump-administration-report#:~:text=Key%20Takeaways,Stock.Adobe.com
[4] https://www.aha.org/system/files/media/file/2025/04/The-Cost-of-Caring-April-2025.pdf
[5] *Ibid.*

This is evidenced by drug manufacturers' frequent price increases that give hospitals little to no time to prepare. For example, Skyrizi, a drug commonly used in hospitals to treat immune-related inflammatory diseases such as Crohn's disease and psoriatic arthritis, experienced a 5.7% price increase in January 2025 and again a 2.5% increase just six months later in July 2025.[6]

The challenges associated with high and rising drug prices are exacerbated because the demand for drugs is increasing dramatically. In addition to new drug therapies becoming available, drugs are more frequently able to take the place of surgery and other clinical interventions in patient care.[7] For example, new chemotherapies are replacing cancer surgeries and glucagon-like peptide-1 (or GLP-1 drugs) have increasingly replaced the need for costly medical interventions to address obesity and obesity-related chronic conditions such as heart disease and diabetes. GLP-1 utilization has skyrocketed nearly 700% from 1 million prescriptions in 2019 to over 8 million in 2024.[8] At the same time, prices for GLP-1 drugs have grown at about 4%-5% annually.[9] The combination of increased demand and pricing for GLP-1s has resulted in a 500% spending increase.[10]

DRUG PRICING AND POLICY ISSUES IMPACTING PATIENTS AND PROVIDERS

Below we highlight some of the most pressing drug pricing issues that are poised to impact patients and providers. We also provide recommendations to address these challenges.

1. The 340B Drug Pricing Program Helps Expand Access to Care for Patients and Communities: For more than 30 years, the 340B Drug Pricing Program has served as a critical tool to help eligible hospitals expand access to care and reduce overall health care costs for underserved patients and communities they serve. The program enables eligible hospitals to stretch limited federal resources by purchasing outpatient drugs at discounted prices, allowing them to reinvest savings directly into patient care and essential community services.

Importantly, 340B is not a federal spending program. It does not rely on taxpayer appropriations and does not increase federal health care expenditures. Instead, it operates by requiring pharmaceutical manufacturers that choose to participate in Medicaid to provide discounts to hospitals that care for a disproportionate share of low-income, uninsured, rural and medically complex patients.

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[6] https://www.46brooklyn.com/branddrug-boxscore
[7] https://www.hfma.org/cost-effectiveness-of-health/how-specialty-drugs-are-remaking-healthcare-and-driving-up-costs/
[8] https://www.kff.org/medicaid/medicaid-coverage-of-and-spending-on-glp-1s/#:~:text=Overall%2C%20the%20number%20of%20GLP,from%201%25%20in%202019
[9] https://www.csrxp.org/dose-of-reality-big-pharmas-glp-1-price-gouging-unsustainable-for-american-patients-and-the-u-s-health-system/#:~:text=Big%20Pharma%20Already%20Hiking%20Prices,in%202023%20by%20five%20percent
[10] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2832114

Hospitals use 340B savings to increase access to care in ways that directly lower system-wide costs. These investments include providing free or reduced-cost medications for uninsured patients, maintaining outpatient oncology and specialty clinics, expanding mental health and substance use disorder services, funding medication management programs, and offering preventive services. By supporting early intervention, continuity of care, and medication adherence, 340B helps prevent avoidable hospitalizations and emergency department visits, outcomes that drive up costs for patients, payers and communities alike.

Despite claims to the contrary, the 340B program remains a relatively small component of the pharmaceutical market. In 2022, 340B discounts accounted for approximately 3% of global drug manufacturer revenues, even as hospitals participating in the program delivered nearly $100 billion in community benefits that year alone. Growth in the program has been driven not by misuse, but by broader health system trends, including rising drug prices, the increasing use of specialty medications and a shift from inpatient to outpatient care settings.

Weakening the 340B program would not reduce health care costs. Instead, it would force hospitals to scale back services, close clinics, and reduce access points. The impact on patients would be particularly acute in rural and underserved areas, leading to delayed care, higher uncompensated care and increased reliance on emergency services. These outcomes would ultimately increase costs across the health care system.

2. Access to Care Impacted by Unreliable Drug Supply Chains: Ensuring the reliability and resilience of the pharmaceutical and medical device supply chains is essential to sustaining high-quality patient care in every community across the nation. Each day in America's hospitals, clinical teams depend on the uninterrupted availability of medications and devices to treat heart attacks, infections, cancer, organ failure, and countless other acute and chronic conditions.

Yet hospitals are increasingly forced to deliver care within a fragile and disruption-prone supply chain. Drug shortages remain widespread, with 253 drugs on the active shortage list as of the second quarter of 2025 — and nearly 60% of shortages now lasting more than two years, a sharp increase from 2019. These shortages disrupt patient care, delay critical treatments, and require hospitals to devote extensive staff time to crisis management rather than direct care.

A core driver of this fragility is the heavy reliance on international manufacturing for both pharmaceutical products and the raw materials required to make them. Hospitals routinely use imported cancer drugs, cardiovascular medications, immunosuppressants, antibiotics and combination therapies. The U.S. sources nearly 30% of its active pharmaceutical ingredients (APIs) from China, and over 90% of generic sterile injectable medications depend on APIs from either India or China. These high-risk dependencies leave patients vulnerable when natural disasters, geopolitical instability, manufacturing failures, or transportation breakdowns interrupt production. As hospitals

across the country witnessed after Hurricane Helene, even domestic facilities are not immune: IV fluid shortages persisted for nearly a year due to storm-related damage to a major U.S. manufacturing plant.

Hospitals also are grappling with structural vulnerabilities within the supply chain itself. Many facilities depend on single-source suppliers for critical products. When a sole manufacturer encounters a quality problem, a contaminated raw ingredient, a sterilization bottleneck or a facility shutdown, hospitals often have no viable alternatives. Hospitals and health systems report that managing just three simultaneous drug shortages can require upwards of 100 person-hours, an unsustainable diversion of clinical and operational resources that should be focused on patient care. Market forces exacerbate these challenges: low reimbursement for generic sterile injectables leaves manufacturers without incentives to maintain redundant facilities, invest in quality improvements or diversify production locations. The result is a brittle market in which low-margin, high-need drugs are most at risk of disappearing from the supply chain and ultimately threatening the ability of hospitals to deliver the care their patients need.

3. Private-payer Policies Undermine Access and Patient Safety: For hospitals across the country, insurer-mandated white bagging and brown bagging policies are creating serious and avoidable risks for patients. These policies require hospitals to obtain clinician-administered drugs through insurer-selected specialty pharmacies rather than through their own hospital pharmacy systems. In white bagging, medications are shipped directly to the hospital on a one-off basis; in brown bagging, they are shipped directly to the patient, who must transport them to the hospital for administration. Both practices jeopardize the safety and reliability of lifesaving therapies.

White bagging and brown bagging policies do not address affordability of federal spending or reduce overall health care costs. Instead, they undermine hospitals' established safety protocols and disrupt the timely care patients depend on. Hospitals cannot verify appropriate temperature control, handling, or integrity of medications shipped from external pharmacies. When clinical conditions change — particularly for cancer patients who often need real-time dose adjustments — externally sourced medications cannot meet clinical needs. This leads to canceled infusions, delayed treatment and worsened patient outcomes. These delays directly impact patients, especially those with cancer, chronic conditions and other serious illnesses requiring precise, reliable drug administration.

White bagging and brown bagging policies also significantly increase the operational and administrative burdens on hospitals. Hospitals must track shipments, manage discrepancies, coordinate with external pharmacies, and resolve insurer-driven delays. Brown bagging further worsens patient care and administrative burdens by making patients responsible for transporting sensitive medications — a practice that would never be accepted in any other high-risk clinical scenario. It also shifts responsibility away from trained clinicians, fragmenting care delivery and increasing the likelihood of harmful errors. The impact is especially acute in rural and underserved communities, where hospitals already operate with thin margins and limited workforce capacity.

Despite insurer claims that white and brown bagging improve efficiency, these are, in fact, insurer-mandated procurement policies that interfere with clinical decision-making, erode care coordination, and threaten patient safety across the health care system.

RECOMMENDED SOLUTIONS

We urge Congress to take the following steps to mitigate the impact of high drug prices and strengthen the U.S. drug supply chain.

1. Protect the 340B Drug Pricing Program: The 340B program is a proven, efficient and targeted tool that strengthens the health care safety net while helping to control downstream costs. Despite its proven track record, some drug manufacturers continue to undermine the program through unilateral efforts to drastically reduce the benefits that eligible hospitals, patients and communities receive from the program.

For example, contract pharmacy arrangements have long served as a critical extension of 340B hospitals, ensuring that vulnerable patients can conveniently access the outpatient drugs they need, whether through a local community pharmacy or mail-order services without traveling long distances to a hospital. This is especially vital for rural hospitals, many of which lack in-house pharmacies and rely almost entirely on contract pharmacy networks to dispense medications. Contract pharmacies also ensure access to specialty drugs that hospitals cannot keep in continuous inventory due to limited distribution. Despite contract pharmacies' clear statutory grounding and longstanding support from the Health Resources and Services Administration, drug manufacturers have imposed unlawful restrictions that threaten hospitals' ability to stretch scarce resources, resulting in millions in losses and reduced access to essential services. Protecting contract pharmacy arrangements is crucial to safeguarding patient access, controlling rising drug costs and maintaining a strong health care safety net.

Recently, some drug manufacturers have attempted to diminish the program by converting the way covered entities access discounted 340B pricing from an upfront discount to a back-end rebate. Under this model, hospitals must first purchase drugs at full price and then seek reimbursement from manufacturers after dispensing them. Hospitals would be required to submit claims data, wait for manufacturer validation and rely on post-purchase rebates to recover the discount. This approach violates longstanding federal policy, fundamentally changes how the program operates, jeopardizes patients' access to drugs, and ultimately will add considerable burden and cost to the health care system.

340B hospitals need access to predictable upfront discounts. Many lack the cash reserves to pay the full cost of high-priced specialty drugs, which can delay treatment, limit drug availability, or force providers to stop offering certain therapies altogether. In addition, manufacturer-imposed conditions increase hospitals' administrative burden and financing costs, increasing the likelihood of disputes and delays that directly affect patients' ability to receive timely, life-saving medications.

We urge Congress to oppose efforts to move 340B pricing to a rebate model. More broadly, we ask Congress to protect the 340B program from efforts by drug companies to diminish its benefits to 340B hospitals and the patients and communities they serve.

2. Enact Policies that Promote Resilience Across Every Stage of the Drug Supply Chain: Hospitals and health systems believe that policies that expand domestic manufacturing capacity while also diversifying global sources of both finished pharmaceuticals and active pharmaceutical ingredients will strengthen the resilience of the drug supply chain. Moreover, policies that support increased domestic redundancy, such as requiring manufacturers to maintain reserves of essential drugs and encouraging geographically distributed production, will help prevent cascading shortages like those seen following Hurricane Helene. At the same time, enhancing transparency by requiring manufacturers to disclose production sites, sourcing locations for APIs and key starting materials, and early warnings about disruptions would give providers and regulators the information necessary to anticipate vulnerabilities and respond proactively.

Policies should align market incentives with quality and reliability to counteract structural weaknesses in the manufacturing of low-margin but high-need drugs. Federal purchasing and contracting frameworks can be strengthened by incorporating failure-to-supply provisions, supporting pull-incentives for essential generics, and encouraging investment in mature, high-quality manufacturing systems. Improved coordination across Department of Health and Human Services' agencies — including the Food and Drug Administration, the Administration for Strategic Preparedness and Response and the Centers for Medicare & Medicaid Services — and the development of predictive analytics and strategic reserves are critical to addressing shortages that increasingly last years rather than months.

These reforms will help ensure hospitals and health systems have uninterrupted access to lifesaving medications and devices, reduce administrative burdens created by supply instability, and safeguard patient care nationwide.

3. Prohibit Harmful White-bagging and Brown-bagging Policies: It is critical for hospitals and health systems to retain the ability to procure and manage clinician-administered medications through their own accredited pharmacy systems. This ensures therapies move through established, rigorously monitored safety channels. Moreover, it ensures that drugs, many of which require special handling and storage, are safe for patients. Mandatory white and brown bagging policies instituted by private payers should be prohibited, especially for high-risk, infused or temperature-sensitive medications that require professional oversight.

White and brown bagging impose unnecessary logistical and administrative burdens on both hospitals and patients. Moreover, they carry unnecessary risks that undermine the very purpose of these medications, which is to improve the health and well-being of patients. **We urge Congress to prohibit brown bagging for clinician-administered**

therapies and hold insurers accountable for operational failures that disrupt patient care. Protecting hospital-centered coordination is essential to preserving safety, reducing waste and maintaining continuous access to specialty medications.

CONCLUSION

Thank you for your commitment to addressing issues on drug prices and the drug supply chain to reduce health care costs for Americans. We look forward to working with you to support and advance these critical issues.

the campaign for
SUSTAINABLE Rx PRICING

Statement for the Record
U.S. House Committee on Energy & Commerce
Subcommittee on Health
Hearing: Health Care Affordability
February 11, 2026

Lauren Aronson
Executive Director, The Campaign for Sustainable Rx Pricing (CSRxP)

Committee Chairman Guthrie, Committee Ranking Member Pallone, Subcommittee Chairman Griffith, Subcommittee Ranking Member DeGette, and members of the U.S. House Committee on Energy & Commerce Subcommittee on Health, the Campaign for Sustainable Rx Pricing (CSRxP) thanks you for the opportunity to submit a statement for the record on our shared goal of improving healthcare affordability for all Americans. We particularly commend your efforts to reduce the unsustainable growth in prescription drug spending, which is the single largest contributor to the healthcare affordability crisis in the U.S. today.[1] CSRxP applauds your bipartisan leadership in seeking to address this critically important issue that impacts millions of American consumers and taxpayers.

CSRxP is a broad-based nonpartisan coalition of leaders committed to fostering an informed discussion on sustainable drug pricing. Our member organizations represent consumers, employers, health plans, hospitals, nurses, pharmacists, pharmacy benefit companies, and physicians. Our coalition is united behind one goal: to lower the cost of prescription drugs for patients. We are committed to developing bipartisan, market-based solutions that promote competition, improve affordability, and enhance list price transparency while maintaining patient access to innovative medications that improve health outcomes and save lives. We believe innovation and affordability must go hand in hand.

I. Big Pharma's Abuse of the Patent System Keeps High-Priced Biologics on the Market without Competition

High-priced brand biologics drive much of the excessive spending on prescription drugs. **Brand biologics made up 5 percent of all prescriptions in the U.S., but comprised 51 percent of total spending on drugs in 2024**.[2] Spending on biologics grew 12.5 percent annually from 2017 to 2021 – a rate that far surpassed the 1.3 percent annual spending growth on traditional small molecule drugs over that same period.[3] In Medicare Part D, prices for biologic medicines have grown more rapidly than

[1] AHIP. Where Does Your Health Care Dollar Go? October 24, 2024.
[2] *Ibid*.
[3] IQVIA. Biosimilars in the United States 2023 – 2027: Competition, Savings, and Sustainability. January 31, 2023.

traditional drugs, rising by more than 300 percent from 2006 to 2022.[4] Similarly, biologics accounted for nearly 90 percent of spending growth on prescription drugs between 2008 and 2021 in Medicare Part B and accounted for 79 percent of all of Part B drug spending in 2021.[5]

Increasing the availability of lower cost biosimilars in the U.S. market will enhance competition for high-priced biologic medicines, thereby reducing prices and overall spending on prescription drugs. Indeed, a recent analysis from the FDA determined that **prices for biosimilars are on average 50 percent lower at launch than prices of their brand reference biologic products at that time**.[6] Reflecting the price favorability of biosimilars, in 2024 alone use of biosimilars generated more than $20 billion in cost savings and, since 2015, biosimilars have saved $56 billion for patients and taxpayers.[7] Along those lines, in Medicare Part B, beneficiary utilization of biosimilars decreased spending by $12.9 billion, or about 31 percent, between 2018 and 2023.[8] **Estimates suggest the potential for total healthcare savings of $234 billion over the next 10 years if new biosimilar competition enters the market.**[9]

Despite the significant potential to improve healthcare affordability, many biosimilars and generic medicines have not been able to enter the market due to Big Pharma's anti-competitive abuse of the U.S. intellectual property system. Research suggests that the anti-competitive nature of the U.S. biologic market cost patients approximately $5 billion from 2015 through 2020.[10] Without action to combat Big Pharma's abusive tactics, patients needlessly will pay an estimated $25 billion in excess drug spending through 2029.[11]

One of the most common strategies that drug makers employ to abuse the patent system and delay competition from lower cost biosimilars is the construction of so-called patent thickets. Under this practice, drug companies apply for and obtain dozens or even hundreds of patents for their branded drugs *after* FDA approval to prevent and delay market entry from less costly generics and biosimilars. Secondary, often non-innovative, patents covering additional indications, dosing and delivery, manufacturing and packaging, and patient safety protocols are obtained to create a thicket of patents. These patent thickets create a nearly insurmountable barrier to competition from lower cost generics and biosimilars for years and, in some cases, decades due to the threat of lengthy, costly, and time-intensive litigation.

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[4] Medicare Payment Advisory Commission. The Medicare prescription drug program (Part D): Status Report. Slide 15. January 11, 2024.
[5] HHS ASPE. Medicare Part B Drugs: Trends in Spending and Utilization, 2008 – 2021. June 9, 2023.
[6] FDA. Fact Sheet: Bringing Lower-Cost Biosimilar Drugs to American Patients. October 29, 2025.
[7] Association for Accessible Medicines. 2025 U.S. Generic & Biosimilar Medicines Savings Report. September 2025.
[8] HHS ASPE. Medicare Part B Enrollee Use and Spending on Biosimilars, 2018 – 2023. January 15, 2025.
[9] Association for Accessible Medicines. 2025 U.S. Generic & Biosimilar Medicines Savings Report. September 2025.
[10] Roy, Avik. "The Growing Power of Biotech Monopolies Threatens Affordable Care." The Foundation for Research on Equal Opportunity. September 15, 2020.
[11] *Ibid*.

Patent thickets have contributed significantly to the "patient affordability crisis" that exists today: extensive patent thickets on just five brand drugs resulted in more than $16 billion in excessive costs in the U.S. drug market in a single year, according to one analysis. [12] [13] Findings from a separate recent study published in *JAMA Health Forum* align with this study, as researchers determined that patent thickets on just four widely prescribed brand biologic products cost patients, taxpayers, and the U.S. healthcare system more than $3.5 billion in excess spending over two years.[14]

Brand drug makers' practice of constructing anti-competitive patent thickets has gained heightened prominence over the past two decades. According to an analysis published in *JAMA*, drug makers increased by 200 percent the number of secondary patent filings used to create anti-competitive patent thickets from 2000 to 2015; in stark contrast, they increased the number of patent filings for original patents by just 15 percent during that same period.[15] Overall, the number of patents for each drug increased by 68 percent during those fifteen years, underscoring brand drug makers' enhanced focus on pursuing secondary patents to form patent thickets for high-priced biologics that block competition from lower cost biosimilars.[16]

Big Pharma continues to deploy its aggressive pursuit of anti-competitive patent thickets today, making prescription drugs and healthcare more broadly unaffordable for far too many Americans. **Nearly three-quarters of all patents were filed for the top 10 selling drugs in the U.S. in 2021 *after* FDA approval,** according to a 2024 study published in *JAMA Internal Medicine*. [17] Patent thicket density peaked 13 years following FDA approval of these top-10 selling medicines, at which time they were protected by a median of 42 (18 – 83) active patents, 66 percent of which were filed after FDA approval.[18] Importantly, most of the 465 patents issued for applications filed after FDA approval for these top-10 selling drugs were for secondary, typically non-innovative, patents: 189 (41 percent) for method of use claims, 127 (27 percent) for formulation claims, and 103 (22 percent) for process or synthesis claims compared to 86 (19 percent) for chemical composition claims and 46 (10 percent) for device claims.[19]

In addition to patent thickets**,** brand name drug makers use other anti-competitive tactics commonly referred to as "evergreening" or "product hopping" to protect their product monopolies and prevent competition from lower cost biosimilars and generics. Under these practices, brand drug makers

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[12] FDA. Fact Sheet: Bringing Lower-Cost Biosimilar Drugs to American Patients. October 29, 2025.
[13] Matrix Global Advisors. Patent Thickets and Lost Drug Savings. January 26, 2023.
[14] Hone D, Tu S, Beall R et al. Estimating Costs of Market Exclusivity Extensions For 4 Top-Selling Prescription Drugs in the US. *JAMA Health Forum*. 2025;6;(8):e252631. Doi:10.1001/jamahealthforum.2025.2631
[15] Tu S, Kesselheim A, Wetherbee K et al. Changes in the Number of Continuation Patents on Drugs Approved by the FDA. JAMA. 2023;330;(5);469-470. Doi:10.1001/jama.2023.11525
[16] *Ibid*.
[17] Horrow et al. Patent Portfolios Protecting 10 Top-Selling Prescription Drugs. *JAMA Intern Med.* Published online May 13, 2024. doi:10.1001/jamainternmed.2024.0836
[18] *Ibid*.
[19] *Ibid*.

lengthen monopolies by seeking approval of "new" products that are essentially the same as original brand products – but with patents covering relatively minor changes like reformulations, such as an extended-release version of the medication, or a combination therapy that combines two existing drugs into one pill. One analysis determined that **consumers lose up to $2 billion per year per each anti-competitive product reformulation produced by "evergreening" and "product hopping."** [20]

Big Pharma's abuse of the U.S. intellectual property system harms consumers and taxpayers and makes prescription drugs unaffordable for millions of Americans. In Medicare, for example, a report from the House Oversight and Investigations Committee found that brand drug makers collectively raised prices on 12 top selling drugs more than 250 times reaching median prices that were nearly 500 percent higher than they were at the time of original market entry through by "product hopping" and constructing patent thickets. [21] The patent thickets collectively comprised 600 patents and delayed competition for high-priced brand biologics from lower cost biosimilars for a total of nearly 300 years and, consequently, needlessly raised prices and spending for Medicare beneficiaries and taxpayers.[22] Similarly, in the U.S. market more widely, a number of blockbuster drugs have not faced competition due to Big Pharma's gaming of the system. For example:

- **Merck's Keytruda for cancer:** Merck has filed nearly 300 patent applications for its anti-cancer biologic Keytruda and has been granted more than 100 patents as a result. [23] The drug maker filed the majority of those patent applications *after* FDA approved Keytruda to construct a patent thicket and delay competition from lower cost biosimilars, which the Initiative for Medicines, Access, and Knowledge (I-MAK) estimates could cost consumers and taxpayers at least $137 billion.[24] [25] This estimate notably does not account for the company's latest product-hopping strategy aimed at switching patients from an IV infusion to a subcutaneous injection formulation in order to help protect the brand product – currently priced at more than $200,000 per year – from competition from lower cost biosimilar IV infusion versions of the treatment once they enter the market.[26]

- **Novo Nordisk and Eli Lilly's GLP-1s for weight loss and diabetes***:* Novo Nordisk has filed 320 patent applications and received 154 patents for semaglutide, the active ingredient in Ozempic, Rybelsus and Wegovy. Despite the fact that the main compound for semaglutide was set to expire in March 2026, the patent thicket constructed by the brand drug maker has lengthened

[20] Shadowen, Steve et. al. "Anticompetitive Product Changes in the Pharmaceutical Industry." *Rutgers Law Journal, Vol*. 41, No. 1-2, Fall/Winter 2009.
[21] House Committee on Oversight and Reform. Drug Pricing Investigation. December 2021.
[22] *Ibid*.
[23] I-MAK. May 2025: Merck's Scheme to Product Hop Keytruda. May 5, 2025.
[24] *Ibid*.
[25] I-MAK. Overpatented, Overpriced: Keytruda's Patent Wall. May 2021.
[26] I-MAK. May 2025: Merck's Scheme to Product Hop Keytruda. May 5, 2025.

market exclusivity for these GLP-1s until December 2031 and will result in excess cost of $166 billion, according to I-MAK.[27] Similarly, Eli Lilly has filed 53 patent applications and received 16 patents for its GLP-1 products, Mounjaro and Zepbound. The main patent compound for these two products is set to expire in 2036, but the patent thicket is expected to extend patent protection for these blockbuster drugs through 2041.

- **AbbVie's Humira for autoimmune diseases***:* AbbVie and its former parent company applied for more than 300 patents for Humira and was granted more than half of those patents over the course of the more than 20 years the drug was on the market without competition.[28] Ninety-four percent of the patents filed on Humira came after initial approval from the FDA. Humira's extensive patent thicket blocked competition helped to generate an excess of $114 billion for AbbVie at the expense of consumers and taxpayers.[29]

Without Congressional action to thwart anti-competitive tactics by Big Pharma such as patent thickets, product hopping and evergreening, drug makers will continue to delay and block competition from lower cost biosimilars and impose billions in excess drug costs on patients, taxpayers, and the U.S. healthcare system overall. The excessive spending on prescription drugs will continue to contribute significantly to the healthcare affordability crisis in the U.S. today. Hence, CSRxP respectfully urges the Committee and the Congress to enact legislation quickly that combats the abuses of Big Pharma in order to reduce unsustainable growth in drug prices and spending.

II. Recommended Policies to Improve Affordability by Enhancing Biosimilar Competition

Given the outsized impact of prescription drugs on healthcare affordability, **CSRxP applauds the Administration and Congress for taking steps to increase competition in the U.S. marketplace with lower cost biosimilars and reduce drug prices and spending.** In particular, CSRxP applauds the recent enactment of bipartisan provisions from the Increasing Access to Generic Drug Applications Act (H.R. 1843), which will reform the Q1/Q2 sameness requirements from the FDA that Big Pharma abuses to extend market exclusivity for high-priced brand medicines. CSRxP also supports the new FDA draft guidance[30] to eliminate comparative efficacy study requirements and streamline biosimilar approvals, as well as the Administration's demonstrated support for automatically designating all biosimilars as interchangeable with their reference products and increasing domestic biosimilar manufacturing.[31] The

[27] I-MAK. The Heavy Price of GLP-1 Drugs: How Financialization Drives Pharmaceutical Patent Abuse and Health Inequities for GLP-1 Therapies. April 2025.
[28] Robbins, R. How a Drug Company Made $114 Billion by Gaming the U.S. Patent System. *The New York Times.* January 28, 2023.
[29] *Ibid*.
[30] FDA. Scientific Considerations in Demonstrating Biosimilarity to a Reference Product: Updated Recommendations for Assessing the Need for Comparative Efficacy Studies. Draft Guidance. October 2025.
[31] FDA. FDA News Release: FDA Moves to Accelerate Biosimilar Development and Lower Drug Costs. October 29, 2025.

new law combined with recent administrative actions should encourage the development of additional lower cost biosimilars.

CSRxP further respectfully urges the Committee and the Congress to build on these actions to foster enhanced competition in the prescription drug marketplace and improve healthcare affordability. To that end, we strongly support and urge the Committee to advance the following pieces of legislation:

1. **Biosimilar Red Tape Elimination Act (H.R. 5526 and S. 1954):** The bipartisan, bicameral legislation introduced by Reps. Pfluger (R-TX), Landsman (D-OH), Auchincloss (D-MA), Crenshaw (R-TX), Vasquez (D-NM), and Owens (R-UT) in the 119th Congress would eliminate outdated FDA requirements to expedite biosimilar substitution and increase competition from more affordable alternatives to high-priced brand name products.

2. **The Drug-price Transparency for Consumers (DTC) Act (H.R. 3789 and S. 229):** The bicameral bill introduced in the 119th Congress by Reps. Taylor (R-OH), Schakowsky (D-IL), Begich (R-AK), Quigley (D-IL), Bresnahan (R-PA), Nunn (R-IA), Vindman (D-VA), and Hinson (R-IA) and Del. Norton (D-DC) would require direct-to-consumer (DTC) advertisements to include price information.

CSRxP further respectfully urges lawmakers to enact additional bipartisan and bicameral legislation under the jurisdiction of other committees that would thwart Big Pharma's anti-competitive behavior and promote competition from lower cost biosimilars and generics:

3. **The Skinny Labels, Big Savings Act (H.R. 6485 and S. 43):** The bill introduced in the 119th Congress would preserve the skinny label pathway for generic drug applicants.

4. **The Eliminating Thickets to Increase Competition (ETHIC) Act (H.R. 3269 and S.2276):** The bill introduced in the 119th Congress would streamline drug patent ligation and help remove barriers to generic and biosimilar market entry.

5. **The Interagency Patent Coordination and Improvement Act (H.R. 1717 and S.79):** This bicameral legislation advanced out of the Senate Judiciary Committee in April 2025 would improve coordination and communication between the FDA and the U.S. Patent and Trademark Office (USPTO) on prescription drug-related issues.

6. **The Affordable Prescriptions for Patients Act (S.1041):** This bill advanced out of the Senate Judiciary Committee in April 2025 would target anti-competitive patent thickets by placing limits on the number of patents a biologic manufacturer can use to prevent competition from lower cost biosimilars.

7. **The Preserve Access to Affordable Generics and Biosimilars Act (S.1096):** This bill advanced out of the Senate Judiciary Committee in April 2025 would ensure that patent settlement agreements facilitate timely competition from more affordable alternative medicines.

8. **The Drug Competition Enhancement Act (S.1040):** This legislation advanced out of the Senate Judiciary Committee in April 2025 would address anti-competitive "product hopping" that involves making small changes to a brand name drug to extend product monopolies.

9. **The Stop STALLING Act (S.1905):** This legislation advanced out of the Senate Judiciary Committee in April 2025 would provide the Federal Trade Commission (FTC) with enhanced authority to stop brand drug companies from exploiting FDA's "citizen petition" process to file sham petitions that delay and prevent FDA approval of more affordable generic and biosimilar medicines.

10. **Medication Affordability and Patent Integrity Act (S.2658):** This bill reintroduced in the 119th Congress would help to prevent abuses of the patent system by requiring biopharmaceutical manufacturers to provide consistent and additional information to the FDA and the USPTO on newly submitted or approved drug applications.

11. **Reforming Evergreening and Manipulation that Extends Drug Years (REMEDY) Act (S.2620):** This legislation reintroduced in the 119th Congress would help to thwart anti-competitive "evergreening" practices in which brand drug manufacturers make minor modifications to existing drugs to maintain market dominance and limit competition from more affordable generic therapies.

III. Conclusion

In conclusion, CSRxP again applauds the bipartisan leadership of the Committee in seeking to tackle the U.S. healthcare affordability crisis. High-priced prescription drugs make healthcare unaffordable for millions of Americans. Without taking major actions to combat the abuses of Big Pharma, the brand drug industry will continue to excessively profit from its anti-competitive pricing practices that needlessly increase drug costs and make healthcare unaffordable for the very people who depend on it most. CSRxP looks forward to our continued work with the Committee and the Congress to develop bipartisan, market-based policies that promote transparency, foster competition, and incentivize value to lower costs for consumers and taxpayers while at the same time maintaining access to the treatments that can improve health outcomes and save lives.

American Cancer Society Cancer Action Network
Questions for Health Subcommittee Hearing: Lowering Health Care Costs for All Americans: An Examination of the Prescription Drug Supply Chain
February 11, 2026

Witnesses:

- Lori M. Reilly, Esq., Chief Operating Officer, PhRMA
- John F. Crowley, President and CEO, Biotechnology Innovation Organization
- John Murphy, President and CEO, Association for Accessible Medicines
- David Marin, President and CEO, Pharmaceutical Care Management Association
- Angie Boliver, President and CEO, Healthcare Supply Chain Association
- Chester "Chip" Davis, Jr., President and CEO, Healthcare Distribution Alliance
- James Gelfand, President and CEO, The ERISA Industry Committee
- B. Douglas Hoey, Chief Executive Officer, National Community Pharmacists Association
- Rachel E. Sachs, Professor of Law, Washington University in St. Louis

Difference between generic sterile injectables and name-brand drugs

Ms. Reilly and Mr. Murphy: In this country we have both generic and branded medicines. Not only are the per-unit prices different between these two categories, but so are the market dynamics and factors that drive shortages. What unique policy solutions does your association recommend to address the shortage of each category (generics and branded)? What are the risks of approaching a one-size-fits-all solution to shortages?

Difference between repatriation of drug manufacturing and creating resilience

Mr. Murphy: Drug shortages have been a chronic and repeating issue for more than a decade. We have sought ways to create a more resilient supply chain through a variety of mechanisms. One approach that has gained more attention recently has been to attempt to move drug production to the U.S. From your organization's perspective, what is the feasibility of moving generic drugs, and how do the economics of their production factor into that? Does moving drug production to the U.S. inherently make it more resistant to shortages, or what other factors should be considered?

Difference between "essential" and "vulnerable" medicines

Ms. Reilly and Mr. Murphy: An executive order in 2020 charged the FDA with creating an "essential medicines" list. The criteria to make this list are those "…most needed for patients in U.S. acute care medical facilities, which specialize in short-term treatment for severe injuries or illnesses and urgent medical conditions." This list only included one of the hundreds of drugs used to treat cancer and does not include many critical medicines that have experienced chronic shortages. Given that many policy proposals intended to address shortages are directed only at drugs on this list, what updates are needed to the "essential medicines" list to ensure it captures the full range of drugs that are vulnerable to

shortages? Does your organization recommend that the FDA or another federal entity create a different list to ensure we comprehensively address the drugs that keep having repeat shortages? If so, how should this list be structured to best capture the most up-to-date information? What additional recommendations do you have to ensure that we have visibility on the state of vulnerable medicines?

Buffer stock

Mr. Murphy, Ms. Boliver, Mr. Davis, and Mr. Hoey: We've seen lots of proposals for hospitals to develop buffer stocks of drugs to avoid shortages. These kinds of buffers can provide time for production recovery after a one-time catastrophic event like a hurricane, war, or other unexpected event. However, in the case of generic sterile injectables, a more significant contributor to shortages is the chronic unsustainable market conditions that cause production capacity to exit or deteriorate. How do buffer stocks fit into the effort to establish sustainable solutions to generic drug shortages relative to other market reforms?

The New York Times https://www.nytimes.com/2023/01/28/business/humira-abbvie-monopoly.html

How a Drug Company Made $114 Billion by Gaming the U.S. Patent System

AbbVie for years delayed competition for its blockbuster drug Humira, at the expense of patients and taxpayers. The monopoly is about to end.

By Rebecca Robbins

Jan. 28, 2023

In 2016, a blockbuster drug called Humira was poised to become a lot less valuable.

The key patent on the best-selling anti-inflammatory medication, used to treat conditions like arthritis, was expiring at the end of the year. Regulators had blessed a rival version of the drug, and more copycats were close behind. The onset of competition seemed likely to push down the medication's $50,000-a-year list price.

Instead, the opposite happened.

Through its savvy but legal exploitation of the U.S. patent system, Humira's manufacturer, AbbVie, blocked competitors from entering the market. For the next six years, the drug's price kept rising. Today, Humira is the most lucrative franchise in pharmaceutical history.

Next week, the curtain is expected to come down on a monopoly that has generated $114 billion in revenue for AbbVie just since the end of 2016. The knockoff drug that regulators authorized more than six years ago, Amgen's Amjevita, will come to market in the United States, and as many as nine more Humira competitors will follow this year from pharmaceutical giants including Pfizer. Prices are likely to tumble.

The reason that it has taken so long to get to this point is a case study in how drug companies artificially prop up prices on their best-selling drugs.

AbbVie orchestrated the delay by building a formidable wall of intellectual property protection and suing would-be competitors before settling with them to delay their product launches until this year.

The strategy has been a gold mine for AbbVie, at the expense of patients and taxpayers.

Barb Teron plans to delay retirement because she is concerned about high out-of-pocket costs for Humira. Nic Antaya for The New York Times

Over the past 20 years, AbbVie and its former parent company increased Humira's price about 30 times, most recently by 8 percent this month. Since the end of 2016, the drug's list price has gone up 60 percent to over $80,000 a year, according to SSR Health, a research firm.

One analysis found that Medicare, which in 2020 covered the cost of Humira for 42,000 patients, spent $2.2 billion more on the drug from 2016 to 2019 than it would have if competitors had been allowed to start selling their drugs promptly. In interviews, patients said they either had to forgo treatment or were planning to delay their retirement in the face of enormous out-of-pocket costs for Humira.

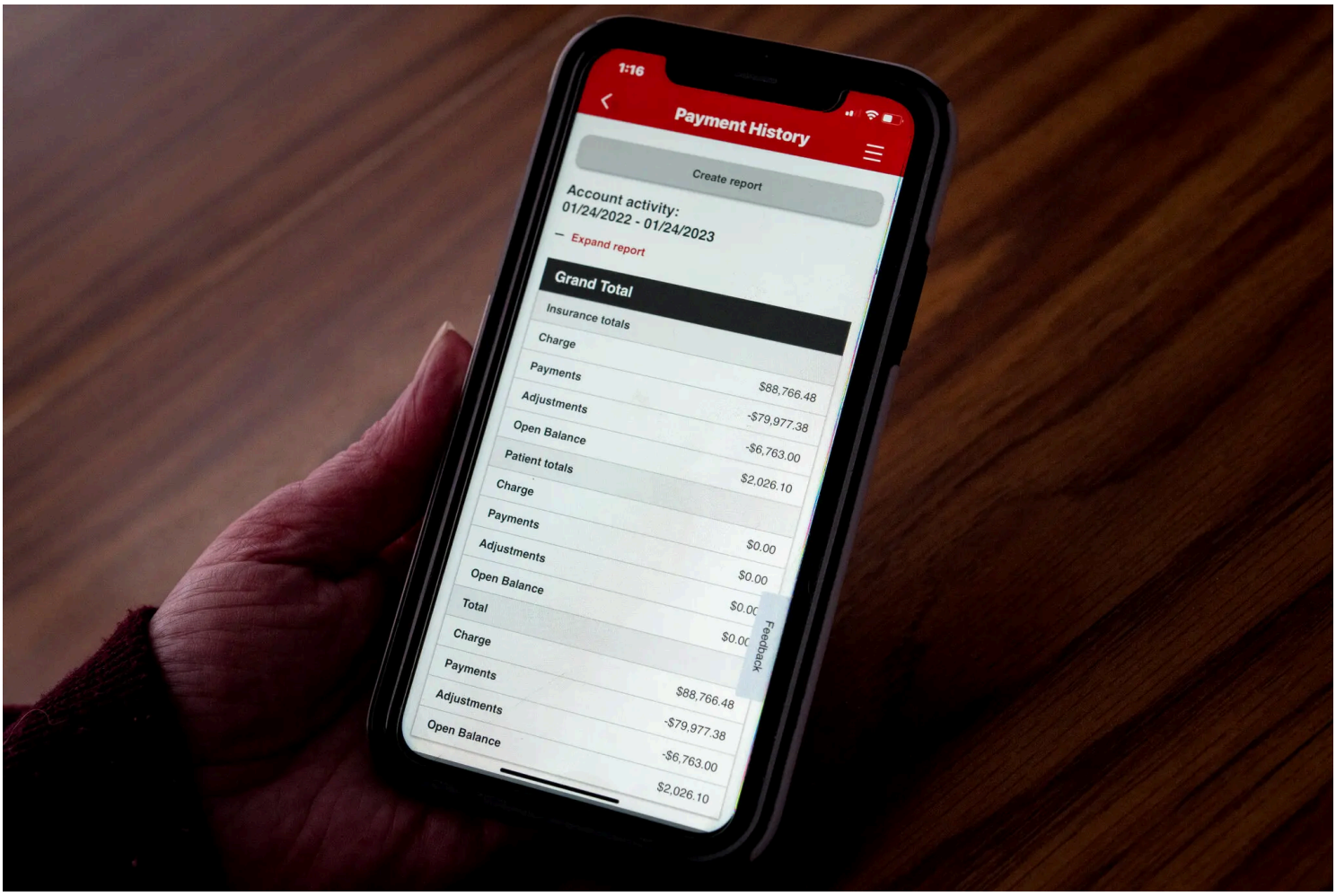
AbbVie did not invent these patent-prolonging strategies; companies like Bristol Myers Squibb and AstraZeneca have deployed similar tactics to maximize profits on drugs for the treatment of cancer, anxiety and heartburn. But AbbVie's success with Humira stands out even in an industry adept at manipulating the U.S. intellectual-property regime.

"Humira is the poster child for many of the biggest concerns with the pharmaceutical industry," said Rachel Sachs, a drug pricing expert at Washington University in St. Louis. "AbbVie and Humira showed other companies what it was possible to do."

Following AbbVie's footsteps, Amgen has piled up patents for its anti-inflammatory drug Enbrel, delaying a copycat version by an expected 13 years after it won regulatory approval. Merck and its partners have sought 180 patents, by one count, related to its blockbuster cancer drug Keytruda, and the company is working on a new formulation that could extend its monopoly further.

Humira has earned $208 billion globally since it was first approved in 2002 to ease the symptoms of rheumatoid arthritis. It has since been authorized to treat more autoimmune conditions, including Crohn's disease and ulcerative colitis. Patients administer it themselves, typically every week or two, injecting it with a pen or syringe. In 2021, sales of Humira accounted for more than a third of AbbVie's total revenue.

An AbbVie spokesman declined to comment. The company's lawyers have previously said it is acting within the parameters of the U.S. patent system. Federal courts have upheld the legality of AbbVie's patent strategy with Humira, though lawmakers and regulators over the years have proposed changes to the U.S. patent system to discourage such tactics.



Ms. Teron, who turns 64 in March, would have liked to retire next year but plans to delay doing so because she fears facing huge costs for Humira on Medicare. Nic Antaya for The New York Times

In 2010, the Affordable Care Act created a pathway for the approval of so-called biosimilars, which are competitors to complex biologic drugs like Humira that are made inside living cells. Unlike generic equivalents of traditional synthetic medications, biosimilars usually are not identical to their branded counterparts and cannot be swapped out by a pharmacist.

The hope was that biosimilars would drastically drive down the cost of pricey brand-name biologics. That is what has happened in Europe. But it has not worked out that way in the United States.

Patents are good for 20 years after an application is filed. Because they protect patent holders' right to profit off their inventions, they are supposed to incentivize the expensive risk-taking that sometimes yields breakthrough innovations. But drug companies have turned patents into weapons to thwart competition.

AbbVie and its affiliates have applied for 311 patents, of which 165 have been granted, related to Humira, according to the Initiative for Medicines, Access and Knowledge, which tracks drug patents. A vast majority were filed after Humira was on the market.

Some of Humira's patents covered innovations that benefited patients, like a formulation of the drug that reduced the pain from injections. But many of them simply elaborated on previous patents.

For example, an early Humira patent, which expired in 2016, claimed that the drug could treat a condition known as ankylosing spondylitis, a type of arthritis that causes inflammation in the joints, among other diseases. In 2014, AbbVie applied for another patent for a method of treating ankylosing spondylitis with a specific dosing of 40 milligrams of Humira. The application was approved, adding 11 years of patent protection beyond 2016.

The patent strategy for Humira was designed to "make it more difficult for a biosimilar to follow behind," Bill Chase, an AbbVie executive, said at a conference in 2014.

AbbVie has been aggressive about suing rivals that have tried to introduce biosimilar versions of Humira. In 2016, with Amgen's copycat product on the verge of winning regulatory approval, AbbVie sued Amgen, alleging that it was violating 10 of its patents. Amgen argued that most of AbbVie's patents were invalid, but the two sides reached a settlement in which Amgen agreed not to begin selling its drug until 2023.

Over the next five years, AbbVie reached similar settlements with nine other manufacturers seeking to launch their own versions of Humira. All of them agreed to delay their market entry until 2023.

Sue Lee stopped taking Humira because of its price. She now relies on free samples of a different drug. Jessica Ebelhar for The New York Times

Some Medicare patients have been suffering as a result.

Sue Lee, 80, of Crestwood, Ky., had been taking Humira for years to prevent painful sores caused by a chronic skin condition known as psoriasis. Her employer's insurance plan had helped keep her annual payments to $60. Then she retired. Under Medicare rules, she would have to pay about $8,000 a year, which she could not afford.

"I cried a long time," she said.

For months, Ms. Lee stopped taking any medication. The sores "came back with a vengeance," she said. She joined a clinical trial to temporarily get access to another medication. Now she is relying on free samples of another drug provided by her doctor. She doesn't know what she'll do if that supply runs out.

Barb Teron, a book buyer in Brook Park, Ohio, plans to delay her retirement because she is worried about Humira's cost. Ms. Teron, who takes Humira for Crohn's disease and colitis, has never had to pay more than $5 for a refill of the drug because her employer's insurance plan picks up most of the tab. The cost, according to a pharmacy app on Ms. Teron's phone, was $88,766 in the past year.

Ms. Teron, who turns 64 in March, would have liked to retire next year, but that would have meant relying on Medicare. She fears that her out-of-pocket costs will spiral higher. "When I look at that $88,000 charge for a year, there's no way," Ms. Teron said.

AbbVie executives have acknowledged that Medicare patients often pay much more than privately insured people, but they said the blame lay with Medicare. In 2021 testimony to a congressional committee investigating drug prices, AbbVie's chief executive, Richard Gonzalez, said the average Medicare patient had to pay $5,800 out of pocket annually. (AbbVie declined to provide updated figures.) He said AbbVie provided the drug for virtually nothing to nearly 40 percent of Medicare patients.

The drug's high price is also taxing employers.

Soon after she started taking Humira, Melissa Andersen, an occupational therapist from Camdenton, Mo., got a call from a human resources representative at her company. The company directly covers its employees' health claims, rather than paying premiums to an insurer. Her Humira was costing the company well over $70,000 a year — more than Ms. Andersen's salary.

The H.R. employee asked if Ms. Andersen would be willing to obtain the drug in an unconventional way to save money. She said yes.

As soon as March, her company plans to fly Ms. Andersen, 48, to the Bahamas, so that a doctor can prescribe her a four-month supply of Humira that she can pick up at a pharmacy there. Humira is much cheaper in the Bahamas, where the industry has less influence than in it does in Washington and the government proactively controls drug pricing.

Even as patients switch to less expensive versions of the drug, Humira's manufacturer, AbbVie, will make money off royalties from rivals. Nic Antaya for The New York Times

It is not yet clear how much the knockoff products will cost and how quickly patients will switch over to them. Billions of dollars in drug spending will ride on the answers to those questions.

"We price our products according to the value they deliver," said Jessica Akopyan, a spokeswoman for Amgen, whose biosimilar product comes to market on Tuesday. She added that the company would "employ flexible pricing approaches to ensure patient access."

Even now, as AbbVie prepares for competitors to erode its Humira sales in the United States, the company will have a new way to make more money from the drug. Under the terms of the legal settlements it reached with rival manufacturers from 2017 to 2022, AbbVie will earn royalties from the knockoff products that it delayed.

The exact sizes of the royalties are confidential, but analysts have estimated that they could be 10 percent of net sales. That could translate to tens of millions of dollars annually for AbbVie.

In the longer run, though, AbbVie's success with Humira may boomerang on the drug industry.

Last year, the company's tactics became a rallying cry for federal lawmakers as they successfully pushed for Medicare to have greater control over the price of widely used drugs that, like Humira, have been on the market for many years but still lack competition.

Rebecca Robbins is a business reporter covering the pharmaceutical industry. She joined The Times in 2020 and has been reporting on health and medicine since 2015.

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