



Paying the Price: How Drug Manufacturers' Greed Is Making Health Care Less Affordable for All of Us

Introduction

Families across America are facing a health care affordability crisis. In 2021, the United States spent \$4.3 trillion on health care, two or three times more per person than other wealthy countries. Yet the U.S. still has some of the worst health outcomes and health care quality.^{1,2} Furthermore, high and rising health care costs force millions of people to choose between the health care they need and basic necessities.³ One-third of Americans say that the cost of medical care interferes with their ability to have food and housing.⁴ And, these high and rising costs drive more than 40% of adults into medical debt, further exacerbating their health and financial struggles.⁵

The high costs of prescription drugs are particularly egregious and play a big part in the affordability crisis. Over the past 15 years, launch prices — the initial prices of drugs set by manufacturers — grew more than 20% each year.⁶ In 2021 alone, the U.S. health care system spent

Families across America are facing a health care affordability crisis...The high costs of prescription drugs are particularly egregious and play a big part.

\$603 billion on prescription drugs (before rebates), and national prescription drug expenditures grew faster than spending on both hospital services, and physician and clinical services.^{7,8} Even after drugs launch, their prices continue to rise at irrationally high rates. For example, the price of Victoza (a popular diabetes and weight loss medication launched in 2010) increased a staggering 42% in just five years, rising from \$7,936 per year in 2015 to \$11,300 per year in 2020.⁹

The impact of these high prescription drug costs on individuals and families who rely on these medications is clear, with almost 30% of adults not taking their medications as prescribed in the past year — rationing their medications, skipping doses, or not filling their prescriptions at all.^{10,11,12} Being forced to make those decisions directly results in poorer health outcomes: rationing or skipping needed medication causes an estimated 125,000 deaths a year.^{13,14}

What many Americans might not know is that not only do high and rising drug prices drive up health care costs for people at the pharmacy counter, but they also drive up health care premiums and deductibles and are often experienced in the form of reduced wages.^{15,16,17} For example, if a person with insurance from their employer is charged a very high price for a prescription drug, not only will those individuals receiving the drug have higher cost sharing, but also that high price will be factored in when establishing future premium costs for all employees insured in the employer's insurance pool. This means we *all* end up paying the price for drug manufacturers' greed, whether or not we take a prescription drug.

For the 60% of U.S. adults currently taking at least one prescription drug and the 25% taking four or more, this means paying for prescription drugs multiple times, including through monthly premium payments, payments to reach their deductibles, and any out-of-pocket expenses paid at the pharmacy counter.¹⁸

What many Americans might not know is that not only do high and rising drug prices drive up health care costs for people at the pharmacy counter, but they also drive up health care premiums and deductibles and are often experienced in the form of reduced wages.

Drug companies make the system work for them, not people who need care

The entire business model of big drug companies is rooted in abusing their monopolistic or quasi-monopolistic position, including price gouging, protecting drug exclusivity through anti-competitive behavior, and increasing profits on old drugs rather than investing in new and innovative treatments to help our nation's families.¹⁹ Simply put, it is a business model that is often rooted in greed. Just this year, a Stanford University business and medical school professor wrote in *Forbes*, "In the 21st century, most drug companies have replaced moonshots with chip shots: strategies aimed at minimizing risk. Rather than chasing the elusive game-changing drug, today's biopharma giants focus on monetizing easy wins."²⁰

Drug companies game the prescription drug market and health care system from beginning to end. When drug companies file patents to bring new drugs to market, they can receive "exclusivity" on those drugs during which time no other company can market a competing drug.^{21,22} In general, under a series of federal laws, most prescription drugs receive between 12 to 16 years of exclusivity and patent protection to reward innovation, with the average being about 14.5 years.²³ This length of time is in part the result of drug companies learning how to abuse this privilege, turning exclusivity and patent protections into a perverse incentive to maintain exclusivity as long as possible in order to maximize profits off old drugs without expending additional resources to develop new ones.²⁴

Drug companies regularly deploy a barrage of tactics to extend their exclusivity periods, keep generics off the market, and maintain their market dominance.²⁵ Common examples include blanketing one drug with multiple and overlapping patents to create a "patent thicket" and paying potential competitors not to produce a generic drug as part of a "pay-for-delay" scheme. In fact, the 10 top-selling drugs on the market today have been granted an average of 74 patents per drug, with an average of 140 patents filed for each of them.²⁶ Importantly, 66% of those patent

Drug companies game the prescription drug market and health care system from beginning to end...turning exclusivity and patent protections into a perverse incentive to maintain exclusivity as long as possible in order to maximize profits off old drugs without expending additional resources to develop new ones.



applications are filed after the drug is approved by the Food and Drug Administration.²⁷ This means that drug manufacturers file new patents, looking to extend drug exclusivity periods, to protect against generic competition with no significant changes made to the original drug itself. Drug companies have an overwhelming financial interest in having market and patent exclusivity that has no relation to improvements to the medications or accessibility of the medications for patients.^{28,29} When Revlimid, a chemotherapy drug, had patent exclusivity, it brought in \$23.8 million per day in revenue. When Keytruda, a cancer drug, had exclusivity it made \$26.8 million per day in revenue. And before its first competition came onto the market in early 2023, Humira, an immunosuppressant drug treating arthritis and Crohn's disease, made \$47.5 million per day in revenue for its manufacturer.³⁰

Finally, once they have established market dominance, drug companies can price gouge freely, raising prices year after year at shocking rates on the medications that they have long since released. These price increases are wholly unrelated to the effectiveness of a drug over time. One study of high-spend drugs showed that seven of the 10 drugs reviewed provided no additional clinical benefit relative to other available drugs to justify their high list price or price hikes.³¹ Some examples of price gouging are particularly predatory. For instance, the drug manufacturer Mylan faced and settled a series of class-action lawsuits resulting from its widely publicized price increases of more than 400% for the EpiPen.³² In another example, even though the FDA first approved the use of naloxone to treat opioid overdose in 1971, the company manufacturing the drug raised the price from \$1 to \$150 for a two-pack of nasal spray in the mid-2010's and charged \$4,500 for an auto-injected version of the drug — putting it out of reach for people who needed it.^{33,34,35} Since then, opioid overdose deaths in the U.S. continued to rise each year, reaching 80,411 deaths in 2021.³⁶

Time and time again, drug companies demonstrate that it is easier and more profitable for them to abuse patent law, limit competition, and raise prices rather than investing in new, innovative treatments that will help people live longer, healthier lives.³⁷



Patent exclusivity brings higher profits:

Revlimid

**\$23.8 MILLION
A DAY**

Keytruda

**\$26.8 MILLION
A DAY**

Humira

**\$47.5 MILLION
A DAY**

before its first competitor entered the market in 2023

High drug costs do not stop at the pharmacy counter

Most people think of high drug costs as a problem when they are filling a prescription. But that is only part of the story. As drug companies continue to price gouge and drug prices go up, consumers are stuck with the bill in more ways than one. That is because drug companies set the list price for their drugs long before they are purchased by the consumer. These underlying prices are paid by insurance providers who in turn pass those high and rising costs along to families and employers in the form of higher insurance premiums.

The problem of costs being pushed onto the consumer is particularly pronounced for the 174 million people with employer-sponsored insurance (ESI), because the premium and deductible structure in these private plans are particularly vulnerable to drug pricing increases as compared to the more standardized structure of Medicare or Medicaid.^{38,39,40} The increased prices charged by drug companies for their drugs become part of the costs analyzed by actuaries to establish updated health insurance premiums, and those increased premiums accrue to all people within an insurance pool, regardless of whether those enrollees take prescription drugs. Put simply, when a drug company abusively increases its prices, the amount insurance companies pay increases, and insurance premiums increase right along with them, for everyone, whether or not they take prescription drugs.^{41,42} In fact, **almost 20% of health insurance premiums are driven by the rising cost of prescription drugs.**⁴³


These premium increases result in a cascade of negative impacts on health care affordability for employers and workers alike. In the past decade, health insurance premiums for those with private insurance rose faster than the rate of inflation and workers' wages.⁴⁴ From 2012 to 2022,

When a drug company abusively increases its prices, the amount insurance companies pay increases, and insurance premiums increase right along with them, for everyone, whether or not they take prescription drugs.



the average premium for family coverage rose 42%, from \$15,745 a year to \$22,463 a year, and the average premium for an individual rose 40%, from \$5,615 a year to \$7,911 a year.⁴⁵ In 2022, health insurance accounted for almost 8% of employee compensation, second only to wages and salary.⁴⁶ As monthly premiums increase, wages rise more slowly because increased health care costs cause employers to spend more of their annual budgets on employee health care and less on employees' take home pay.⁴⁷ This problem is especially concerning for individuals who are already paid low wages and are then forced to contribute a disproportionately high percentage of their wages toward health insurance premiums.⁴⁸

On top of increased health insurance premiums, high drug prices result in other increased health insurance-related costs in the form of deductibles, coinsurance, and copays — for prescription drugs and other health services alike. With 50% of out-of-pocket spending on medical care (including prescription drugs) experienced through deductibles, increasing deductibles leaves consumers paying more out-of-pocket and exposes more consumers to the full price of their prescription drugs and other health care services.^{49,50} In 2019, a Consumer Reports survey revealed that 30% of adults who take a prescription drug regularly experienced out-of-pocket cost increases from one year to the next, and 12% said those costs went up by \$100 or more.⁵¹ The average deductible for covered workers in 2022 was \$1,763 for single coverage, and just one year later, in 2023, that average had grown to \$2,004.^{52,53} Increases to deductibles and premiums affect all people with health insurance, regardless of what kinds of care they are seeking, and when taken in combination with the stagnating effect on wages, it is clear that high and rising drugs costs are compounding families' financial insecurity.^{54,55}



As monthly premiums increase, wages rise more slowly because increased health care costs cause employers to spend more of their annual budgets on employee health care and less on employees' take home pay.



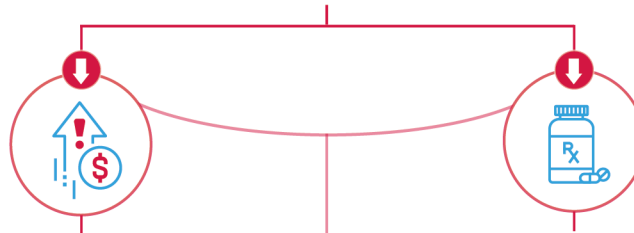
The Greedy Games of Drug Companies and the Consequences of Sky High Drug Prices



PATENT ABUSE

Drug companies game the patent system to extend market exclusivity for their drugs. They activate multiple and overlapping patents to delay competition and pay competitors to delay further drug development and production.

MARKET EXCLUSIVITY ALLOWS DRUG COMPANIES TO:



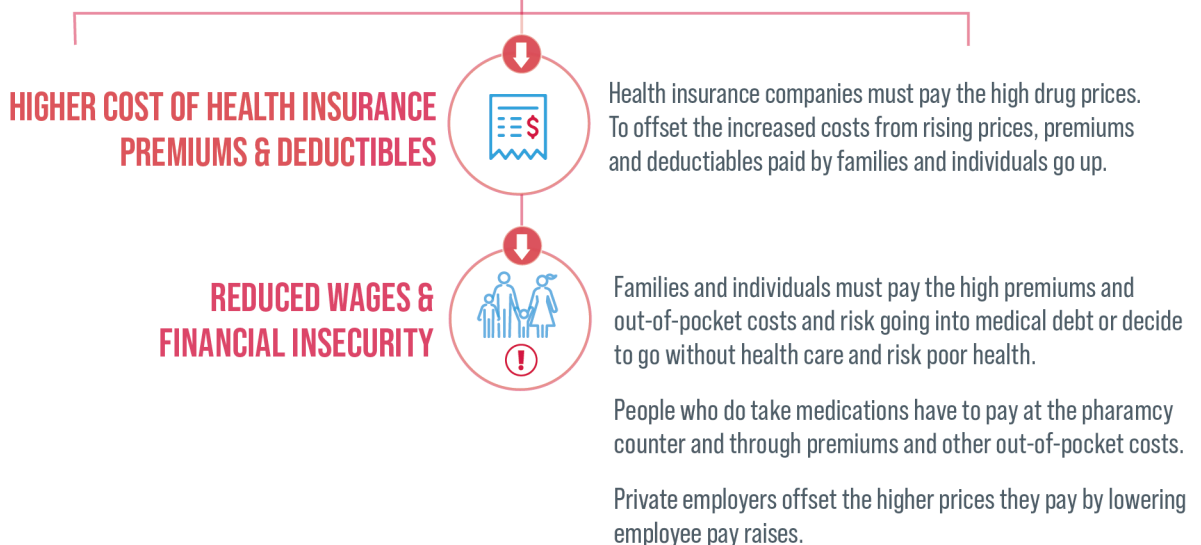
PRICE GOUGE

Lack of competition leads to monopolies and allows for drug companies to raise prices year after year.

LIMIT DRUG INNOVATION

It is easier and more profitable for drug companies to raise prices and protect current drugs than develop new innovative ones.

THESE BEHAVIORS ARE IN DIRECT OPPOSITION TO FAMILIES AND INDIVIDUALS, WHO END UP WITH:



To improve health care affordability for everyone, we must address the root causes of high drug costs

As policymakers explore ways to improve health care affordability, they should advance drug pricing reforms that protect families and individuals from high out-of-pocket costs at the pharmacy while also getting to the root of the problem of high and rising list prices so that costs are lowered and not just shifted to premiums. **When solutions focus only on what is paid at the pharmacy counter, not the underlying price, big drug companies can continue their abusive practices, raising prices behind the scenes and leaving all consumers to pay through their premiums and deductibles without insight into the reasons for the increases.**

Recently, Congress took important steps to systemically bring down drug prices and rein in the rate of skyrocketing price increases. The Inflation Reduction Act (IRA) of 2022 is landmark legislation that includes several key provisions to address the underlying prices of certain medications and control the rate of price increases for drugs in Medicare. The IRA gave the Centers for Medicare & Medicaid Services the ability to negotiate drug prices in Medicare for the first time in our nation's history.⁵⁶ In 2026, the negotiated prices for the first 10 drugs will go into effect, with additional drugs added to the list in following years.⁵⁷ These drugs are the most expensive for Medicare, do not have generic competition, and have been on the market for a long time (more than seven years for small molecule drugs and 11 years for biologics).^{58,59} The list of the first 10 drugs includes medications for cancer treatment, prevention and treatment of blood clots, management of arthritis, Crohn's disease, and diabetes — lifesaving and life-sustaining drugs that collectively cost \$50.5 billion a year in Medicare Part D alone.⁶⁰ Negotiation is expected to result in \$98.5 billion in savings for Medicare over the next 10 years and significant savings on out-of-pocket costs for consumers once the negotiated prices go into effect.^{61,62}

The IRA also implemented inflationary rebates for any drug whose price rises faster than the rate of inflation in one year,⁶³ meaning drug companies have to pay back to Medicare the difference between the new increased price and what the price would have been at the rate of inflation.⁶⁴ This provision gets to the root of drug pricing and health care affordability: that the already too-high prices are increasing quickly with no connection to market characteristics — like inflation — that are standardized across our economy. The incentive not to raise drug prices as high or as quickly will help keep money in the pockets of consumers.⁶⁵ This provision is expected to result in a net federal deficit reduction of \$63.2 billion over 10 years, including \$56.3 billion in Medicare savings.⁶⁶

HOW CONGRESS CAN FURTHER REIGN IN PRESCRIPTION DRUG COSTS:

The IRA takes monumental steps in lowering prescription drug costs for the federal government as well as seniors and people with disabilities. Congress can build on the foundation laid by the IRA to further rein in prescription drug costs and make health care more affordable for everyone in two key ways:



1 Broadening the impact of the IRA to the commercial market to better protect all consumers from high and irrational drug costs.

- » **Expand the number of drugs eligible for negotiation in Medicare and allow commercial insurance to voluntarily adopt the negotiated rate:** The IRA limits the number of drugs that are subject to government negotiation each year, and the negotiated prices are not automatically available to consumers with private health insurance.⁶⁷ This leaves millions of consumers with private coverage, including ESI, vulnerable to continued high and irrational prescription drug prices. The secretary of the Department of Health and Human Services should be authorized — and required — to expand the list of drugs subject to negotiation and to extend all negotiated prices to private sector health insurance, should insurance plans want to adopt the Medicare negotiated price.
- » **Extend the inflationary rebates into the commercial market:** The IRA requires that drug manufacturers pay a rebate when they increase prices faster than the rate of inflation for some drugs covered under Medicare Part B and almost all covered drugs under Medicare Part D. Drug manufacturers that do not pay the rebate would face a significant monetary penalty. Inflation rebates should be extended to include drugs covered in the commercial market to better protect individuals in employer-sponsored plans and other private plans from drug manufacturers' high prices and exorbitant yearly increases. This would also protect those in the commercial market from potential cost shifting by drug companies attempting to make more off all other payers when their prices drop in Medicare.⁶⁸



2 Taking steps to address, and correct for, the abusive behavior of drug manufacturers, which leads to high prices in the first place.

- » **End patent abuses:** For decades, drug companies have systematically abused patent and market exclusivity rules to block competition. Policymakers should explore ways to address these decades of abuse and take action to eliminate practices like pay-for-delay and patent thickets.
- » **Support bringing generic drugs to the market faster:** Generics, on average, cost 20% to 70% less than their brand-name counterparts, making them an affordable and effective solution for many consumers.⁶⁹ Generics bring competition to the market and lower costs for specific drugs by as much as 85% when multiple competitors exist.⁷⁰ The administration should simplify the generic approval process and help to bring affordable prescription drugs to the consumers who are currently struggling to pay for their medications.^{71,72}

Conclusion

The high and rising cost of prescription drugs is at the core of the U.S. health care affordability crisis. The prices of drugs threaten the financial security of families and individuals and, by extension, their health. Drug companies abuse the patent system, delay the entry of generic drugs, and price gouge to support their greed while families and individuals go into medical debt; ration or skip medications; and choose between food, housing, and their prescriptions all because of the cost. Even those not taking prescription drugs are left with difficult financial decisions due to rising insurance premiums, higher deductibles, and stagnant wages — all of which can be tied back to rising drug costs.

No one should have to choose between their lifesaving or life-sustaining medication and basic needs. Big drug companies are making consumers pay the price, in multiple ways, purely to inflate their own profits, and it is past time to realign their business interests with the needs of our nation's families.

No one should have to choose between their lifesaving or life-sustaining medication and basic needs.

Endnotes

- ¹ Wager, Emma, Jared Ortaliza, and Cynthia Cox. 2022. “How Does Health Spending in the U.S. Compare to Other Countries?” Peterson-KFF Health System Tracker, January 21, 2022. Peterson-Kaiser Health System Tracker. 2017. <https://www.healthsystemtracker.org/>.
- ² Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan, “It’s Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt,” *Health Affairs* 38, no. 1 (January 2019): 87–95, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144>.
- ³ Alex Montero et al., “Americans’ Challenges With Health Care Costs,” KFF, July 14, 2022, <https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/>.
- ⁴ *Americans’ Views on Healthcare Costs, Coverage and Policy* (NORC at the University of Chicago and West Health Institute, 2018), <http://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Topline.pdf>.
- ⁵ Lunna Lopes et al., “Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills,” KFF, June 16, 2022, <https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/>.
- ⁶ Benjamin N. Rome, Alexander C. Egilman, and Aaron S. Kesselheim, “Trends in Prescription Drug Launch Prices, 2008–2021,” *JAMA* 327, no. 21 (2022): 2145–2147, <https://jamanetwork.com/journals/jama/article-abstract/2792986>.
- ⁷ Sonal Parasrampur and Stephen Murphy, *Trends in Prescription Drug Spending, 2016–2021* (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, September 2022), <https://aspe.hhs.gov/sites/default/files/documents/88c547c976e915fc31fe2c6903ac0bc9/sdp-trends-prescription-drug-spending.pdf>.
- ⁸ “NHE Fact Sheet,” CMS.gov, U.S. Centers for Medicare & Medicaid Services, last modified September 6, 2023, <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet>.
- ⁹ Dena Bunis, “Drugmakers Face Penalties for Price Hikes Above Inflation,” AARP, February 15, 2023, <https://www.aarp.org/politics-society/advocacy/info-2022/drugmakers-penalties-price-hikes.html#:~:text=The%20report%20also%20found%2C%20for,rising%20from%20%247%2C936%20to%20%2411%2C300>.
- ¹⁰ “Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say It’s Difficult to Afford Their Medicines, Including Larger Shares Among Those With Health Issues, With Low Incomes and Nearing Medicare Age,” KFF, n.d., <https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/>.
- ¹¹ Ashley Kirzinger et al., “Public Opinion on Prescription Drugs and Their Prices,” KFF, August 21, 2023, <https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/>.
- ¹² Kirzinger et al., “Public Opinion.”
- ¹³ Hayden Bosworth et al., “Medication Adherence: A Call for Action,” *American Heart Journal* 162, no. 3 (September 2011): 412–424, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3947508/>.
- ¹⁴ Fred Kleinsinger, “The Unmet Challenge of Medication Nonadherence,” *Permanente Journal* 22 (2018): 18–33, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6045499/>.
- ¹⁵ *Prescription Drug Spending in the U.S. Health Care System: An Actuarial Perspective* (Washington, DC: American Academy of Actuaries, March 2018), <https://www.actuary.org/content/prescription-drug-spending-us-health-care-system>.
- ¹⁶ Rome, Egilman, and Kesselheim, “Prescription Drug Launch Prices.”
- ¹⁷ “Rising Health Care Costs Mean Lower Wages,” T.H. Chan School of Public Health, Harvard University, n.d., <https://www.hsph.harvard.edu/news/hsph-in-the-news/baicker-health-care-costs-wages/#:~:text=%E2%80%9CWhen%20health%20care%20costs%20go,according%20to%20the%20Census%20Bureau>.

¹⁸ Kirzinger et al., “Public Opinion.”

¹⁹ Bailey Reavis and Hazel Law, *The Reality of Prescription Drug Innovation: Drug Manufacturers Limit Innovation to Protect Patents and Profits* (Washington, DC: Families USA, August 2023), <https://familiesusa.org/wp-content/uploads/2023/08/Drug-Companies-Limit-Innovation-for-Profit-2.pdf>.

²⁰ Robert Pearl, “Pharma Companies: A Conglomerate of Monopolies,” *Forbes*, January 31, 2023, <https://www.forbes.com/sites/robertpearl/2023/01/31/pharma-companies-a-conglomerate-of-monopolies/?sh=387ee8f81ce1>.

²¹ Tahir Amin, “Patent Abuse Is Driving Up Drug Prices. Just Look at Lantus” STAT, December 7, 2018, <https://www.statnews.com/2018/12/07/patent-abuse-rising-drug-prices-lantus/>.

²² Aaron S. Kesselheim, Michael S. Sinha, and Jerry Avorn, “Determinants of Market Exclusivity for Prescription Drugs in the United States,” *JAMA Internal Medicine* 177, no. 11 (2017): 1658–1664, <https://www.commonwealthfund.org/publications/journal-article/2017/sep/determinants-market-exclusivity-prescription-drugs-united>.

²³ Kesselheim, Sinha, and Avorn, “Determinants of Market Exclusivity.”

²⁴ David Blumenthal, “It’s the Monopolies, Stupid!” The Commonwealth Fund, May 24, 2018, <https://www.commonwealthfund.org/blog/2018/its-monopolies-stupid>.

²⁵ Patricia Kelmar and Abe Scarr, *The Cost of Prescription Drug Patent Abuse: How Drug Companies Abuse the Patent System and Demand Inflated Monopoly Prices in America* (U.S. PIRG Education Fund, April 2023), <https://pirg.org/edfund/resources/the-cost-of-prescription-drug-patent-abuse/>.

²⁶ Tahir Amin and David Mitchell, “Big Pharma’s Patent Abuses Are Fueling the Drug Pricing Crisis,” *Time*, February 24, 2023, <https://time.com/6257866/big-pharma-patent-abuse-drug-pricing-crisis/#:~:text=A%20recent%20national%20report%20reveals,for%20very%20minor%20product%20modifications>.

²⁷ Amin and Mitchell, “Big Pharma’s Patent Abuses.”

²⁸ Abbey Meller and Hauwa Ahmed, “How Big Pharma Reaps Profits While Hurting Everyday Americans,” Center for American Progress, August 30, 2019, <https://www.americanprogress.org/article/big-pharma-reaps-profits-hurting-everyday-americans/>.

²⁹ Eliot Fishman, *Our Broken Drug Pricing and Patent System Diverts Resources Away From Innovation and Into Mergers, Patent Gaming and Price Gouging* (Washington, DC: Families USA, August 2021), https://familiesusa.org/wp-content/uploads/2021/08/RX-2021-209_Innovation-Drug-Pricing-Issue-Brief.pdf.

³⁰ Amin and Mitchell, “Big Pharma’s Patent Abuses.”

³¹ Fishman, Drug Pricing and Patent System.

³² Emily Willingham, “Why Did Mylan Hike EpiPen Prices 400%? Because They Could,” *Forbes*, August 21, 2016, <https://www.forbes.com/sites/emilywillingham/2016/08/21/why-did-mylan-hike-epipen-prices-400-because-they-could/?sh=16854130280c>.

³³ Brianna Jones and Sarah Kaminer Bourland, *Drug Companies Keep Raising Prices in the Midst of a Pandemic* (Patients for Affordable Drugs, June 28, 2020), <https://patientsforaffordabledrugs.org/2020/06/28/covid-price-hikes-report/>.

³⁴ Kate Johnson, Sandra Wilkniss, and Hemi Tewarson, *Public Health Crises and Pharmaceutical Interventions: Improving Access While Ensuring Fiscal Sustainability* (Washington, DC: National Governors Association Center for Best Practices, 2018), <https://www.nga.org/wp-content/uploads/2018/08/Public-Health-Crises-and-Pharmaceutical-Interventions.pdf>.

³⁵ Fishman, Drug Pricing and Patent System.

³⁶ “Drug Overdose Death Rates,” National Institute on Drug Abuse, June 30, 2023, <https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#:~:text=Opioid%2Dinvolved%20overdose%20deaths%20rose,with%2080%2C411%20reported%20overdose%20deaths>.

³⁷ Fishman, *Drug Pricing and Patent System*.

³⁸ “Annual Number of People Enrolled in Employer-Sponsored Health Insurance (ESI) in the U.S. From 1987 to 2021,” Statista, 2023, <https://www.statista.com/statistics/1365618/population-enrolled-in-esi-in-the-us/>.

³⁹ “2023 Medicare Costs,” CMS Product No. 11579, Medicare.gov, U.S. Centers for Medicare & Medicaid Services, November 2022, <https://www.medicare.gov/Pubs/pdf/11579-medicare-costs.pdf>.

⁴⁰ “Cost Sharing,” Medicaid.gov, U.S. Centers for Medicare & Medicaid Services, n.d., <https://www.medicare.gov/medicaid/cost-sharing/index.html>.

⁴¹ AHIP, “Your Health Care Dollar: Vast Majority of Premium Pays for Prescription Drugs and Medical Care,” press release, September 6, 2022, <https://www.ahip.org/news/press-releases/your-health-care-dollar-vast-majority-of-premium-pays-for-prescription-drugs-and-medical-care>.

⁴² Tina Reed, “Insurers Blame Specialty Drug Costs for Rising Premiums. This Report From California Shows Why,” Fierce Healthcare, January 7, 2019, <https://www.fiercehealthcare.com/payer/report-prescription-drug-costs-driving-up-insurance-premiums>.

⁴³ Kim Keck, “Six Ways We’re Lowering Drug Prices,” Blue Cross Blue Shield of America, March 3, 2022, <https://www.bcbs.com/the-health-of-america/articles/six-ways-were-lowering-drug-prices#:~:text=In%20the%20United%20States%20today.cost%20can%20be%20much%20higher>.

⁴⁴ Sam Hughes, Emily Gee, and Nicole Rapfogel, “Health Insurance Costs Are Squeezing Workers and Employers,” Center for American Progress, November 29, 2022, <https://www.americanprogress.org/article/health-insurance-costs-are-squeezing-workers-and-employers/#:~:text=Over%20the%20past%20decade%2C%20ESI.growth%20between%202015%20and%202019>.

⁴⁵ Gary Claxton et al., *Employer Health Benefits: 2022 Annual Survey* (San Francisco, CA: KFF, October 2022), <https://www.kff.org/report-section/ehbs-2022-section-1-cost-of-health-insurance/#:~:text=The%20average%20family%20premium%20has%20grown%20at%20a%20similar%20rate,2012%20to%20%2422%2C186%20in%202022>.

⁴⁶ Hughes, Gee, and Rapfogel, “Health Insurance Costs.”

⁴⁷ Hughes, Gee, and Rapfogel, “Health Insurance Costs.”

⁴⁸ Hughes, Gee, and Rapfogel, “Health Insurance Costs.”

⁴⁹ Debra Bozzi, Katie Martin, and Aditi Sen, “ESI Enrollees Paid \$853 on Average Out-of-Pocket for Health Care in 2020, But Some People Paid Over Four Times as Much,” Health Care Cost Institute, December 20, 2022, <https://healthcostinstitute.org/all-hcci-reports/esi-enrollees-paid-853-on-average-out-of-pocket-for-health-care-in-2020-but-some-people-paid-over-four-times-as-much#:~:text=On%20average%2C%20people%20with%20ESI,as%20well%20as%20prescription%20drugs>.

⁵⁰ Salam Abdus, “Financial Burdens of Out-of-Pocket Prescription Drug Expenditures Under High-Deductible Health Plans,” *Journal of General Internal Medicine* 36, no. 9 (September 2021): 2903–2905, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7500984/>.

⁵¹ Lisa Gill, “The Shocking Rise of Prescription Drug Prices: Here’s Why Prices Keep Going Up, Plus How to Combat the Sticker Shock — and Still Protect Your Health,” Consumer Reports, November 26, 2019, <https://www.consumerreports.org/drug-prices/the-shocking-rise-of-prescription-drug-prices/>.

⁵² Gary Claxton et al., *Employer Health Benefits*.

⁵³ Kat Tretina and Heidi Gollub, “How Much Does Health Insurance Cost in 2023?” USA Today, October 25, 2023, <https://www.usatoday.com/money/blueprint/health-insurance/how-much-is-health-insurance/>.

⁵⁴ KFF, “Poll.”

- ⁵⁵ Hughes, Gee, and Rapfogel, “Health Insurance Costs.”
- ⁵⁶ U.S. Department of Health and Human Services, “HHS Releases Initial Guidance for Historic Medicare Drug Price Negotiation Program for Price Applicability Year 2026,” press release, March 15, 2023, <https://www.hhs.gov/about/news/2023/03/15/hhs-releases-initial-guidance-historic-medicare-drug-price-negotiation-program-price-applicability-year-2026.html>.
- ⁵⁷ Juliette Cubanski, Tricia Neuman, and Meredith Freed, “Explaining the Prescription Drug Provisions in the Inflation Reduction Act,” KFF, January 24, 2023, <https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/>.
- ⁵⁸ Juliette Cubanski, “FAQs About the Inflation Reduction Act’s Medicare Drug Price Negotiation Program,” KFF, August 8, 2023, <https://www.kff.org/medicare/issue-brief/faqs-about-the-inflation-reduction-acts-medicare-drug-price-negotiation-program/>.
- ⁵⁹ Meena Seshamani, “Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026,” memorandum, Center for Medicare, U.S. Department of Health and Human Services, June 30, 2023, <https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf>.
- ⁶⁰ “Medicare Drug Price Negotiation Program: Selected Drugs for Initial Price Applicability Year 2026,” Centers for Medicare & Medicaid Services, August 2023, <https://www.cms.gov/files/document/fact-sheet-medicare-selected-drug-negotiation-list-ipay-2026.pdf>.
- ⁶¹ Cubanski, Neuman, and Freed, “Prescription Drug Provisions.”
- ⁶² “FACT SHEET: Biden- Harris Administration Announces First Ten Drugs Selected for Medicare Price Negotiation,” The White House, August 29, 2023, <https://www.whitehouse.gov/briefing-room/statements-releases/2023/08/29/fact-sheet-biden-harris-administration-announces-first-ten-drugs-selected-for-medicare-price-negotiation/#:~:text=Nearly%2019%20million%20seniors%20and,average%20of%20%242%2C500%20per%20year>.
- ⁶³ Cubanski, Neuman, and Freed, “Prescription Drug Provisions.”
- ⁶⁴ U.S. Department of Health and Human Services, “HHS Releases Initial Guidance for Medicare Prescription Drug Inflation Rebate Program,” press release, February 9, 2023, <https://www.hhs.gov/about/news/2023/02/09/hhs-releases-initial-guidance-for-medicare-prescription-drug-inflation-rebate-program.html>.
- ⁶⁵ Cubanski, Neuman, and Freed, “Prescription Drug Provisions.”
- ⁶⁶ Cubanski, Neuman, and Freed, “Prescription Drug Provisions.”
- ⁶⁷ H.R. 5376 – Inflation Reduction Act of 2022, <https://www.congress.gov/bill/117th-congress/house-bill/5376>.
- ⁶⁸ Sara Hansard, “Employer Benefit Seen From New Medicare Drug Price Law,” Bloomberg Law, September 28, 2022, <https://news.bloomberglaw.com/health-law-and-business/employer-benefit-seen-from-new-medicare-drug-price-law>.
- ⁶⁹ “How to Get Generic Drugs and Low-Cost Prescriptions,” Federal Trade Commission, October 2023, <https://consumer.ftc.gov/articles/generic-drugs-low-cost-prescriptions#:~:text=Generics%20have%20the%20same%20active,to%20your%20doctor%20and%20pharmacist>.
- ⁷⁰ Ted Sherwood, “The Generic Drug Approval Process,” U.S. Food and Drug Administration, current as of March 17, 2022, <https://www.fda.gov/drugs/news-events-human-drugs/generic-drug-approval-process>.
- ⁷¹ Kerstin Noëlle Vokinger et al., “Strategies That Delay Market Entry of Generic Drugs,” JAMA Internal Medicine 177, no. 11 (November 2017): 1665–1669, <https://www.commonwealthfund.org/publications/journal-article/2017/sep/strategies-delay-market-entry-generic-drugs>.
- ⁷² “Generic Competition and Drug Prices,” U.S. Food and Drug Administration, current as of October 5, 2023, <https://www.fda.gov/about-fda/center-drug-evaluation-and-research-cder/generic-competition-and-drug-prices>.

This publication was written by:
Hazel Law, Policy Analyst, Families USA
Sophia Tripoli, Senior Director, Health Policy and Director,
Center for Affordable Whole-Person Care, Families USA

The following Families USA staff contributed to the preparation of this material
(listed alphabetically):

Ben Anderson, Deputy Senior Director, Health Policy
Justin Charles, Digital Media Associate
Nichole Edralin, Associate Director, Design and Publications
Bailey Reavis, Manager, Federal Relations
Jen Taylor, Senior Director, Federal Relations



1225 New York Avenue NW, Suite 800, Washington, DC 20005
202-628-3030 info@familiesusa.org FamiliesUSA.org [facebook / FamiliesUSA](https://www.facebook.com/FamiliesUSA) [twitter / @FamiliesUSA](https://twitter.com/FamiliesUSA)