Written Testimony of

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before the

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on

"Making Medicines More Affordable: How Competition Can Lower Drug Prices"

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Mr. Chairman and Members of the Committee,

Thank you for the opportunity to testify today. I am Robert Weissman, co-president of Public Citizen. Public Citizen is a national public interest organization with more than 1 million members and supporters. For more than 50 years, we have advocated with some considerable success for consumer protection, corporate and government accountability, and ethics and honest government. Over those five decades, we have focused especially on drug safety and affordability.

Big Pharma price gouging of Americans is worse now than at any time in our more than 50 years of existence. It has, truly, become intolerable and unsustainable.

In very rough outline, here's how drug development, manufacture, approval and sales work in the United States:

1. The U.S. government spends tens of billions on the most fundamental biomedical research, with a hand in the research for almost every prescription drug that reaches the market. It gives away the fruits of its research unconditionally.
2. The U.S. government confers 20-year patent monopolies on new drugs and bestows other marketing exclusivities on drug corporations.
3. The U.S. government is the world's largest drug purchaser, but with modest exceptions, it forbids its largest drug purchasing program from negotiating prices with drug companies.

In other words, there is no "free market" for the pharmaceutical industry. The industry relies on massive public subsidies; it exploits government-granted monopolies; and it leverages its political power to prevent its largest purchaser from exercising its negotiation power.

The result of this system is exactly the injustice one would predict: massive profits for drug companies, sky-high CEO pay, monopoly pricing and widespread rationing of important and sometimes life-saving medicines.

This is a system that needs to be fundamentally reformed. Aggressive pro-competition tools – like those included in the Prescription Drug Price Relief Act – can meaningfully constrain Big Pharma's price gouging and make medicines affordable for all Americans.

The first section of this testimony provides an overview of the failures of the current drug development and pricing system, identifying market failures and their profound consequences for Americans.

The second section evaluates the efforts of the Trump administration to address the problems. It points out that President Trump has rightfully criticized drug corporations for charging far more in the United States than they do in other rich countries; but shows how the administration's policies have failed and will fail to address price gouging – and, in some cases, will make things worse.

The third section focuses on solutions that employ market forces to curtail Big Pharma's pricing abuses. It emphasizes how the Prescription Drug Price Relief Act, introduced by Ranking Member Senator Bernie Sanders, would leverage the power of generic competition to ensure U.S. consumers and payors are not subjected to prices higher than those in other rich countries; and it notes how similar results could be achieved by expanding and improving the existing Medicare drug negotiation system.

Big Pharma's Price Gouging and its Consequences

Big Pharma-controlled drug pricing in America is working wonders for drug corporations, but it is a disaster for American consumers and public health.

Consider these facts:

- More than 40 percent of Americans report that they have skipped drug treatments or otherwise haven't taken medicines as prescribed because of cost.[1]
- The median launch price of a new drug in the United States jumped from $2,115 in 2008 to $180,007 in 2021, a 20 percent annual inflation rate, according to researchers at Brigham and Women's Hospital in Boston.[2] Since 2021, the median price has more than doubled, to $370,000 in 2024.[3]
- The top 20 Big Pharma companies have reported more than $400 billion in profits over the last three years (2023-2025).[4]
- The top 20 Big Pharma CEOs take home more than $300 million in collective pay every year.[5]
- The United States pays 3-4 times more for prescription drugs than other rich countries.[6]

There's nothing natural, or market-based, about these facts. They are the result of Big Pharma leveraging its political power to impose and maintain subsidies, monopolies and manifold protections.

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[1] Audrey Kearney, Alex Montero, Julian Montalvo III, Isabelle Valdes, Ashley Kirzinger, and Liz Hamel, "Public Views on Prescription Drug Costs: Regulation, Affordability and TrumpRx,"
KFF, March 13, 2025, https://www.kff.org/public-opinion/public-views-on-prescription-drug-costs-regulation-affordability-and-trumprx/

[2] Robert Langreth, "New Drug Prices Soar to $180,000 a Year on 20% Annual Inflation," *Bloomberg*, June 7, 2022, https://www.bloomberg.com/news/articles/2022-06-07/new-drug-prices-soar-to-180-000-a-year-on-20-annual-inflation

[3] Deena Beasley, "Prices for new US drugs doubled in 4 years as focus on rare disease grows," Reuters, May 22, 2025, https://www.reuters.com/business/healthcare-pharmaceuticals/prices-new-us-drugs-doubled-4-years-focus-rare-disease-grows-2025-05-22/

[4] Public Citizen analysis based on company 10-K disclosures.

[5] Public Citizen analysis based on company 10-K disclosures.

[6] Office of Assistant Secretary for Planning and Evaluation (ASPE), "Comparing Prescription Drugs in the U.S. and Other Countries: Prices and Availability," January 31, 2024, https://aspe.hhs.gov/reports/comparing-prescription-drugs

There's also nothing acceptable about this. There's no legitimate reason for the United States to pay 3-4 times more for medicines than the price in other countries. And there's certainly no legitimate reason, nor any excuse, for 4-in-10 Americans to ration the medicines they need.

The problem starts with this basic fact: Government funding contributes to the invention and development of virtually every new drug. In 2018, researchers at Bentley University found that "NIH funding contributed to published research associated with every one of the 210 new drugs approved by the Food and Drug Administration from 2010-2016." "Collectively," they found, "this research involved more than 200,000 years of grant funding totaling more than $100 billion."[7]

This government funding – just shy of $50 billion annually but now in some jeopardy due to the actions and chaos of the Robert F. Kennedy, Jr.-led Department of Health and Human Services – is a good thing and a source of American strength.

The problem is that the government does not request anything in return for its largesse. Under current law and practice over the last four decades, the National Institutes of Health (NIH) manages its ownership rights with the goal of getting new drugs to market – without regard to whether drug corporations will charge reasonable prices for the medicines invented with public funds.

(In 2024[8] and renewed in 2025,[9] NIH took a modest step to redress this problem, requiring companies licensing NIH drug discoveries to submit "access plans" detailing how the products they license will be made widely available in the United States or in poor countries. This new policy was a giant step forward conceptually, but practically is likely to have modest impacts because of weak standards for establishing what "access" means, lack of enforceability, and applicability only to NIH-developed inventions, not those developed in universities and elsewhere with NIH funds.[10])

Building on this unconditional subsidy for Big Pharma is the most fundamental reason that drug companies can charge such high prices: the government grants them monopolies.[11] These include

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[7] Ekaterina Galkina Cleary, Jennifer M. Beierlein, Navleen Surjit Khanuja, Laura M. McNamee, and Fred D. Ledley, "Contribution of NIH funding to new drug approvals 2010–2016," *PNAS* 115, no. 10 (February 2018): 2329-2334, https://www.pnas.org/doi/10.1073/pnas.1715368115.

[8] NIH Intramural Research Program Access Planning Policy (rescinded), May 24, 2024, https://grants.nih.gov/grants/guide/notice-files/NOT-OD-25-062.html

[9] NIH Intramural Research Program Access Planning Policy, July 24, 2025, https://grants.nih.gov/grants/guide/notice-files/NOT-OD-25-136.html

[10] Jishian Ravinthiran, Bryce Robinson, Peter Maybarduk, Rachel M. Cohen, Pascale Boulet, Michelle Childs, Mihir Mankad, Isabel Parkey, James Love, Melissa Barber, Brook Baker "Integrating Equity Into Licensing Agreements For Taxpayer-Funded Technologies," Health Affairs, December 19, 2024, https://www.healthaffairs.org/content/forefront/integrating-equity-into-licensing-agreements-taxpayer-funded-technologies

[11] Aaron S. Kesselheim, MD, JD, MPH[1]; Jerry Avorn, MD[1]; Ameet Sarpatwari, "The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform," JAMA, Vol. 316, No. 8, August 23/30, 2016, https://jamanetwork.com/journals/jama/article-abstract/2545691 ("The most important factor that allows manufacturers to set high drug prices is market exclusivity, protected by monopoly rights awarded upon Food and Drug Administration approval and by patents.")

20-year patent monopolies for new inventions – not just the original drug, but also small modifications or means to deliver the drug – plus other marketing exclusivities.

The rationale for granting use and marketing monopolies is to incentivize research and development – the logic is that companies will undertake risky research if they know they will be rewarded with a monopoly and that competitors will not be able to free ride on their research – but the system is badly out of whack and growing worse by the year. In the best case, monopolies are an inefficient way to pay for research. But we've long ago left the best-case scenario.

Drug prices have no relationship to actual R&D costs whatsoever, with the Congressional Budget Office concluding "current R&D spending does not influence the future prices of the drugs that result from that spending."[12] Top drug companies receive 163% of their *global* R&D costs from just the excess revenue generated in the United States,[13] underscoring that these companies often earn well beyond their R&D spending and don't need to raise prices to maintain R&D investments.

In fact, drug corporations simply charge what the market will bear. And given the inelastic demand for important medicines and the role of third party payors, the market will bear outlandish prices, even if that means many will go without.

One way to address the problem of monopoly pricing is to limit the period of monopoly or to introduce generic competition when monopolists abuse their power. Generic competition generates huge price reductions, typically 80 percent within a few years for markets with many generic sellers.[14] Unfortunately, Big Pharma has been able to leverage its political and legal power in recent decades to create new and extended exclusivities.

Another way to address monopoly pricing abuses is to empower bulk purchasers to leverage their power to negotiate down monopoly prices. Medicare, however, which is the world's largest drug buyer, was prohibited from the inception of the Medicare Part D program from negotiating drug prices. Under the Medicare Modernization Act that created the Medicare drug benefit, Medicare Part D is not allowed to "interfere with the negotiations between drug manufacturers and pharmacies and [Part D plan] sponsors."[15] While Medicare Part D plan sponsors can obtain substantial rebates from both drug manufacturers and pharmacies, the federal program is prohibited from leveraging its purchasing power to realize economies of scale, due to this "noninterference" clause. The result is wildly inflated prices for Medicare, nearly twice those

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[12] Congressional Budget Office, "Research and Development in the Pharmaceutical Industry," August 2021, https://www.cbo.gov/publication/57126

[13] Nancy L. Yu, Zachary Helms and Peter B. Bach, "R&D Costs For Pharmaceutical Companies Do Not Explain Elevated US Drug Prices," Health Affairs, March 7, 2017, https://www.healthaffairs.org/content/forefront/r-d-costs-pharmaceutical-companies-do-not-explain-elevated-us-drug-prices

[14] Office of Assistant Secretary for Planning and Evaluation (ASPE), "Analysis of New Generic Markets Effect of Market Entry on Generic Drug Prices: Medicare Data 2007-2022," January 2025, https://aspe.hhs.gov/sites/default/files/documents/510e964dc7b7f00763a7f8a1dbc5ae7b/aspe-ib-generic-drugs-competition.pdf

[15] 42 USC 1395w-111(i).

paid by the much smaller Veterans Health Administration, which effectively negotiates the prices it pays.[16]

Consider how all these factors come together exacerbate each other for just a single medicine, Xtandi (generic name: enzalutamide):

Xtandi is a medicine to treat advanced prostate cancer, sold by Astellas and Pfizer. Xtandi is exorbitantly priced by any measure. In 2020, it cost $129,000 per year, or close to $90 per capsule.[17] The price of Xtandi is three to five times higher in the United States than in other rich countries. In 2020, Astellas and Pfizer made more money selling Xtandi in the U.S. than from the rest of the world combined.[18] The year before, Medicare spent more than $1 billion on the drug before rebates. A Canadian manufacturer once offered to sell generic enzalutamide to the U.S. government for $3 per capsule – one thirtieth of the original manufacturers' price – but the offer was declined.[19]

Many patients can't afford the sky-high price. For one patient who was briefly placed on the treatment, filling just one prescription cost $625 out-of-pocket. "Drugs like Xtandi force families to focus on and worry about price tags," he wrote in a 2022 submission to the Department of Health and Human Services. "Please allow American prostate cancer patients the same right to access affordable care as patients around the world."[20] The price for those without insurance is now much higher.

The high price of Xtandi also raises concerns about health equity. Black men die from prostate cancer at twice the rate of white men and may have a disproportionate need for the exorbitantly priced drug.[21]

Xtandi was invented at University of California, Los Angeles (UCLA) with U.S. government grants provided by the National Institutes of Health and the U.S. Army. U.S. government funds also helped pay for the early-stage clinical trials of the drug.

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[16] General Accountability Office, "Prescription Drugs: Department of Veterans Affairs Paid About Half as Much as Medicare Part D for Selected Drugs in 2017," January 14, 2025, https://www.gao.gov/products/gao-21-111

[17] $88.54 per capsule, with four capsules required every day. See "Xtandi: 2021-2022 Request to US Department of Health and Human Services to Use the US Government's Rights in Patents," Knowledge Ecology Network, https://www.keionline.org/xtandi2021

[18] Rick Claypool and Zain Rizvi, "United We Spend," Public Citizen, last modified September 30, 2021, https://www.citizen.org/article/united-we-spend-big-pharma-us-international-revenue-report

[19] Ed Silverman, "Small company offers Medicare cheap version of pricey cancer drug," *STAT*, April 27, 2016, https://www.statnews.com/pharmalot/2016/04/27/cancer-medicare-xtandi-biolyse-pharma

[20] Robert Mermell to Xavier Becerra, January 26, 2022, https://www.keionline.org/wp-content/uploads/Xtandi-Letter-Mermell-26Jan2022.pdf

[21] Ilkania Chowdhury-Paulino, Caroline Ericsson, Randy Vince Jr., R. et al., "Racial disparities in prostate cancer among black men: epidemiology and outcomes," Prostate Cancer Prostatic Diseases 25 (2022): 397–402, https://www.nature.com/articles/s41391-021-00451-z

In 2016 and 2021, the organizations Knowledge Ecology International and the Union for Affordable Cancer Treatment and prostate cancer patients petitioned the NIH and Department of Defense to exercise authorities to make generic versions available. [22] They refused. [23]

Medicare drug negotiation will enable some modest relief to Xtandi price-gouging. The maximum price for Medicare in 2027 will be $84,000 annually – a significant reduction, but insufficient, far too late in the drug's life cycle and not available to private payors.[24]

This is, unfortunately, a representative, not exceptional case.

In general, drug corporations know they can't pull the same tricks in other countries that are permitted in the United States, so their business model relies on gouging U.S. consumers and taxpayers, while still earning substantial profits overseas. Based on its review of internal company documents, the House Oversight Committee reported that Pfizer "targeted the U.S. market for price increases. A draft internal Pfizer presentation from 2016 explicitly linked Pfizer's global profitability to its ability to raise prices in the United States, noting that growth was driven by 'price increases in the U.S.'"[25]

This is a situation that demands action. The proportion of patients who can't afford prescribed medicines has steadily increased in recent decades. The Big Pharma burden on the health sector and the national economy has grown, such that drug spending accounts for nearly 3 percent of GDP, and more than twice as much an economic share as in other countries. And, the problem is severe and growing worse, rapidly: From 2017 to 2022, "U.S. average price per unit for the top 50 drugs increased faster over time compared to the rest of the world."[26]

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[22] Knowledge Ecology International to Francis Collins, Ashton Carter, and Sylvia Mary Mathews Burwell, January 14, 2016, https://www.keionline.org/wp-content/uploads/Xtandi-March-In-Request-Letter-14Jan2016.pdf ; Clare Love and David Reed to Mark Esper, February 4, 2019, https://www.keionline.org/wp-content/uploads/enzalutamide-march-in-royalty-free-Clare-Love-David-Reed-Army-4Feb2019.pdf.

[23] See Francis Collins to Andrew Goldman, June 20, 2016, https://www.techtransfer.nih.gov/sites/default/files/documents/policy/pdfs/Final_Response_Goldman_6.20.2016.pdf and Alejandro Lopez-Duke to Andrew Goldman, https://www.keionline.org/wp-content/uploads/USArmy_Response_Xtandi_Request_5Aug2016.pdf

[24] Rebecca Robbins, "U.S. Announces Negotiated Prices for 15 Drugs Under Medicare," New York Times, November 25, 2025, https://www.nytimes.com/2025/11/25/health/drugs-prices-medicare.html

[25] Drug Pricing Investigation," Committee on Oversight and Reform, U.S. House of Representatives, December 2021,https://oversightdemocrats.house.gov/sites/democrats.oversight.house.gov/files/DRUG%20PRICING%20REPORT%20WITH%20APPENDIX%20v3.pdf

[26] Sonal Parasrampuria and Stephen Murphy, "Comparing U.S. and International Market Size and Average Pricing for Prescription Drugs, 2017-2022," Office of the Assistant Secretary for Planning and Evaluation (ASPE), December 2024, https://www.ncbi.nlm.nih.gov/books/NBK611829

Trump Administration: Strong Rhetoric, No Results

President Trump has criticized Big Pharma for its unreasonable prices and correctly said that there's no reason for the United States to pay more than other rich countries.[27]

Unfortunately, he has not pursued policies to remedy that wrongdoing. His key initiatives on drug pricing are shrouded in secrecy and beset by confusion, and will either have no or limited effect on pricing – or make the problem worse.

Most notably, President Trump had denounced the gap between U.S. and other countries' drug price levels and negotiated a series of agreements with drug companies that purport to require them to offer the United States the lower prices they charge overseas (known as "most favored nation" or MFN pricing).

Purportedly to advance this objective, the Trump administration has negotiated a series of secret deals with drugmakers. The secrecy makes it impossible to determine whether these deals will lower some drug prices or if the terms are designed to protect Big Pharma or to be easily gamed by drug companies. Public Citizen has tried to obtain the text of these agreements under the Freedom of Information Act and has sued to force their disclosure.[28]

But there is no reason to believe these secret deals contain meaningful price concessions. The drug industry,[29] Wall Street analysts and even CMS Administrator Oz[30] have all predicted minimal financial impact from Trump's dealmaking with pharma.[31] Dr. Oz suggested drug companies helped "design a plan that doesn't hurt [them]."

Regarding so-called "most-favored nation" prices offered to Medicaid, the Trump Administration has provided little transparency and thus it is difficult to evaluate the potential impact, but Medicaid already typically gets the best price on drugs in United States; and Medicaid beneficiaries pay minimal or no out-of-pocket drug costs.

Depending on the structure of the arrangement, it's possible the deals will actually increase costs in the United Staes. For example, a drug corporation may avoid costly inflationary rebates it

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[27] "President Donald J. Trump Announces Actions to Get Americans the Best Prices in the World for Prescription Drugs," July 31, 2025, https://www.whitehouse.gov/fact-sheets/2025/07/fact-sheet-president-donald-j-trump-announces-actions-to-get-americans-the-best-prices-in-the-world-for-prescription-drugs/

[28] Public Citizen v. U.S. Department of Health and Human Services, January 27, 2026, https://www.citizen.org/wp-content/uploads/1-Complaint-1.27.2026.pdf

[29] Caitlin Owens, "Big Pharma financially unfazed by drug price deals," Axios, February 19, 2026, https://www.axios.com/2026/02/19/big-pharma-trump-drug-price-deals

[30] Peter Sullivan, "Trump officials try to make peace with pharma," Axios, February 18, 2026, https://www.axios.com/2026/02/18/trump-drug-prices-fda

[31] Jessica Merrill, "Drug Makers Confront Headwinds In 2026, But MFN Doesn't Seem Like A Big One," Pnk Sheet, February 11, 2026, https://insights.citeline.com/scrip/drug-pricing/drug-makers-confront-headwinds-in-2026-but-mfn-doesnt-seem-like-a-big-one-YYQBO72NSNCHBE6EBPKF2GSDB4

would otherwise be obligated to pay, as media reports suggest may be the case regarding Eliquis.[32]

A review of industry investor calls shows that Big Pharma is not overly concerned about MFN deals. "Company leaders frequently stress that agreements are 'bounded,' 'channel-specific,' or 'limited in duration,'" according to an analysis by the Brookings Institution's Richard Frank. "Notably, in financial reports, few companies provide precise estimates of MFN revenue impact. … The lack of large, quantified adjustments may suggest one of the following: Either the revenue effects are manageable relative to total sales, or the scope remains too uncertain to model definitively."[33]

The second prong of the administration's policy is to initiate a government operated direct-to-consumer sales website, TrumpRx. This is a structurally deficient proposal that fails to recognize that most people have drugs costs covered, at least in part, by insurance. That structural deficiency is exacerbated by the terrible execution of TrumpRx, with few drugs available and promotion of brand-name products for which generic alternatives exist. In fact, for most people, TrumpRx will not provide any relief from high drug prices; others may be tricked into paying more for prescription drugs.

More than 40 percent of the drugs listed on TrumpRx (28 out of 69) have generics already approved by FDA that can be purchased more cheaply than the "discount" prices on TrumpRx. For some of these drugs, the difference can amount to hundreds of dollars per fill.[34] Most of the products listed on TrumpRx are decades old; the median time on the market of the listed drugs is 20 years. One product has been on the market for 84 years.[35]

In the vast majority of cases, it will be cheaper for patients with insurance to use their insurance instead of TrumpRx. Insurance typically covers most of the drugs listed on TrumpRx with low out-of-pocket costs.[36] For insured patients, going through TrumpRx could provide a double whammy of higher drug costs and those costs not counting toward insurance deductibles or out of pocket maximums.

TrumpRx claims to provide "the world's lowest prices on prescription drugs," but prices remain higher than in other wealthy countries. Wegovy injection deals on TrumpRx start at $199 for the first two monthly fills of the lowest dose and then rise to $349 per month; coupons must be used by the end of June 2026 to secure this deal. Meanwhile, Wegovy can be purchased for $186 in

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[32] Michael McCaughan, "The Eliquis Paradox: US Price Caps Trigger Double-Digit Growth," Pink Sheet, February 19, 2026, https://insights.citeline.com/pink-sheet/market-access/pricing-debate/the-eliquis-paradox-us-price-caps-trigger-double-digit-growth-5XQEILOEPNEX5MIDRTCQTFSTK4

[33] Richard Frank, "What Earnings Calls And SEC Filings Reveal About The State Of Pharma," Health Affairs, March 31, 2026, https://www.healthaffairs.org/content/forefront/earnings-calls-and-sec-filings-reveal-state-pharma

[34] John Wilkerson, J. Emory Parker, Chelsea Cirruzzo, Elaine Chen and Daniel Payne, "TrumpRx claims to offer the lowest prices. But many drugs have cheaper generics," Stat, February 6, 2026, https://www.statnews.com/2026/02/06/trumprx-discount-drug-website-undercut-by-cheaper-generics/

[35] Conclusions based on Public Citizen analysis of data available on TrumpRx.

[36] Rebecca Robbins, "How to Tell if You Will Save Money Using TrumpRx," New York Times, February 6, 2026, https://www.nytimes.com/2026/02/06/health/trumprx-prescription-drug-prices-consumers.html

Denmark, $137 in Germany, and $92 in the United Kingdom. Amgen's arthritis treatment Enbrel costs nearly $1,000 more a month on TrumpRx than its Medicare negotiated price for 2026.

The third prong of the administration's drug pricing policy has been to undermine price negotiations through Medicare. The tax and budget reconciliation bill included language to exempt and delay negotiations for drugs that would have otherwise been selected for negotiations this year, including Keytruda, Darzalex and Opdivo. These exemptions are projected to reduce savings from the negotiation program by $8.8 billion or more,[37] directly impacting cancer patients and taxpayers who will pay more for cancer treatments as a result. Merck has already made more than $160 billion selling the anti-cancer drug Keytruda since its launch in 2014;[38] it's long past time for patient and taxpayers to obtain some price relief.

President Trump has also proposed to further weaken Medicare drug price negotiations by prohibiting negotiations on all medicines until at least 11 years after they first receive FDA approval, meaning negotiated prices would not be available to Medicare and its beneficiaries for at least 13 years.[39] This would effectively exclude many of these medicines from negotiations entirely,[40] or shorten the period patients have access to lower negotiated prices to only one or two years before generics enter the market, blunting the impact of the law, potentially costing seniors and Medicare tens of billions more each year.[41]

Last, President Trump has pressed for other countries to raise their drug prices, on the misguided theory that higher prices overseas will lead to lower prices in the United States. In reality, higher prices overseas will simply lead to higher profits for Big Pharma, as well as lower access in those countries.

Big Pharma acts rationally on the world market: It charges the highest prices it can in each market. As the Congressional Budget Office notes, "Manufacturers maximize their global revenue by charging different prices in different market segments, depending on the demand characteristics of those segments. Those demand characteristics reflect differences both in buyers' willingness to pay and in the regulations affecting prices in various markets. Differences in drug prices paid in different countries in part reflect that market segmentation, as do differences in prices paid by various purchasers within the United States."[42]

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[37] Congressional Budget Office, letter to Reps. Frank Pallone and Richard Neal and Senator Ron Wyden, October 20, 2025, https://www.cbo.gov/system/files/2025-10/61818-Pallone-etal-orphan-drugs-letter-10-20-25.pdf

[38] Sydney P. Freedberg, Brenda Medina and Denise Ajiri, "How Merck turned its wonder drug into a blockbuster — and priced out cancer patients worldwide," International Consortium of Investigative Journalists, April 13, 2026, https://www.icij.org/investigations/cancer-calculus/merck-keytruda-cancer-drug-price

[39] "Lowering Drug Prices by Once Again Putting Americans First," EO 14273, April 15, 2025, https://www.federalregister.gov/documents/2025/04/18/2025-06837/lowering-drug-prices-by-once-again-putting-americans-first

[40] Public Citizen, Issue Brief: Protecting Medicare Drug Price Negotiations, March 7, 2025, https://www.citizen.org/article/issue-brief-protecting-medicare-drug-price-negotiations/

[41] Public Citizen, "Delaying Drug Price Negotiations = More Big Pharma Price Gouging," April 4, 2025, https://www.citizen.org/article/delaying-drug-price-negotiations-enables-more-pharma-price-gouging/

[42] Congressional Budget Office, "Alternative Approaches to Reducing Prescription Drug Prices," October 2024, https://www.cbo.gov/publication/60812

Drug prices are lower in other countries compared to the United States because those countries have systems in place to moderate the monopoly pricing excesses of prescription drug corporations. Better deals achieved by other countries are not "subsidized" through higher U.S. prices – drug companies are not in the business of selling their products at a loss, occasional humanitarian programs notwithstanding. And, as already discussed, drug pricing is disconnected from R&D costs – and drug company revenues far greater than needed to support R&D efforts.

Harnessing Market Forces to Restrain Big Pharma Price Gouging

Our pharmaceutical pricing system needs an overhaul. There is no good reason for the United States, a nation which invests so much public money in biomedical research and whose public dollars so vitally support private drug development, to pay three of four times more for medicines than the United States. And it's public health and moral outrage that, in the richest country in the world, more than 40 percent of adults ration their medicines because they are too expensive.

More competition can address these issues. But because the problems are so severe and the market failures so complete, modest measures won't do the trick. That's in part because medicines are so expensive that modest price reductions won't materially change the unaffordability of drugs for many consumers and payors. Even more consequentially, it is because Big Pharma can offset modest limits on specific pricing abuses by intensifying them in other areas. Aggressive approaches are needed.

There are multiple possible market-based avenues to tackle excessive drug prices. The basic standard should be that the United States does not pay more than other rich countries. And the basic approach should be to use market tools to lower prices if drug corporations abuse their monopoly power to price gouge American consumers.

This is the approach employed by the Prescription Drug Price Relief Act of 2025, S. 1818. The Prescription Drug Price Relief Act would, in a nutshell, authorize generic competition for drugs where a manufacturer charges more in the United States than it does in other rich countries. The introduction of generic competition will drive prices down to an affordable level.

Yale University researchers project massive savings from this approach – overall national savings of at least $184 billion. Their analysis concludes that savings would total 51 percent price reductions for private insurers (totaling $82.2 billion), 62 percent for Medicare ($70.5 billion) and 35 percent for Medicaid ($12.9 billion). Patient out-of-pocket spending would fall 40 percent, according to the Yale study.[43]

The Prescription Drug Price Relief Act is a simple and direct approach, but it is also careful and nuanced. Two features in particular are worth underscoring. First, the Act would require payment of a reasonable royalty to the original manufacturer. Licensing is commonplace in the industry

[43] Yang Ye, Abhishek Pandey Meagan C. Fitzpatrick and Alison P. Galvani, "Estimating US savings on outpatient prescription pharmaceuticals from international reference pricing," Proceedings of the National Academy of Sciences, January 5, 2026, https://www.pnas.org/doi/10.1073/pnas.2520871122

and the Act's baseline is the average industry royalty rate. That payment will ensure fairness to the original manufacturer and its efforts to develop and bring the drug to market, and also ensure fair compensation in line with Constitutional standards around "takings."

Second, the Act provides discretion to the Secretary of Health and Human Services to set royalties instead based on consideration of a range of factors, including the value of the drug to patients; the size of the affected patient population; the amount of federal subsidies to develop the drug; the clinical benefits of the drugs compared to existing therapies; and the revenues obtained by the manufacturer, relative to actual development costs. These factors will enable the Secretary, as appropriate, to calibrate the royalty rate to reflect particular circumstances. For example, in the case of an important treatment, expensive to develop, for a disease that affects a small population, the Secretary could set a higher royalty. Or, by contrast, where a company relied heavily on public support, contributed modestly to R&D expenses and has already generated substantial revenue, the Secretary could set a royalty rate lower than the baseline.

Another approach to achieve the same objective as the Prescription Drug Price Relief Act would be to build on the successes of the Medicare drug negotiation provisions. The elements of this approach would:

- Establish the median price paid in other countries as the presumptive fair price.
- Eliminate the delay period for negotiation, so that Medicare negotiations begin immediately upon market launch.
- Expand Medicare negotiation to cover all drugs, just like is done for the Veterans Health Administration.
- Make the negotiated Medicare price available to all payers, including to uninsured individuals.

Even with aggressive reforms to drive down price – such as those that could be achieved by the Prescription Drug Price Relief Act or expanded Medicare price negotiations, accumulated expenses for many people will be unsustainable. Complementing the effort to drive down price should be an extension of Medicare's $2000 out-of-pocket cap to the private insurance market.

The Urgent Need for Bold Action

Americans are as united in demanding bold action to address Big Pharma price gouging as they are about anything. Well over 8 in 10 – including 89 percent of Republican voters – say Big Pharma's excessive profits are a major contributing factor to unreasonably high drug costs. Nearly 9 in 10 Americans want speeded up generic competition. There is roughly comparable support for strengthening Medicare price negotiation.[44]

[44] Audrey Kearney, Alex Montero, Julian Montalvo III, Isabelle Valdes, Ashley Kirzinger, and Liz Hamel, "Public Views on Prescription Drug Costs: Regulation, Affordability and TrumpRx,"
KFF, March 13, 2025, https://www.kff.org/public-opinion/public-views-on-prescription-drug-costs-regulation-affordability-and-trumprx/

The overwhelming support for aggressive measures to end Big Pharma's price gouging reflects people's lived experience in rationing the drugs they need, or being forced to pay more than they can afford. It also reflects a widespread awareness that prescription drugs are cheaper, much cheaper, in other countries.

Americans have every reason to be mad. It is our money that fuels drug development. It is our government that confers the monopolies that Big Pharma exploits. It is all of us – as consumers and taxpayers – who are forced to pay Big Pharma's monopoly shakedown prices.

Market tools, aggressively deployed, can make a difference. Responding to price gouging by insisting we won't pay more than other rich countries and promoting generic competition, as the Prescription Drug Price Relief Act does, or leveraging the power of Medicare as a buyer, can yield dramatic national savings -- $184 billion annually, and climbing.

The issue is not how to re-design a broken system that benefits Big Pharma at the expense of the rest of us. We know how to do that. The issue is whether Congress and the Executive have the political will to do it.