**Before the Senate Finance Committee Minority Staff**

**Response to Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients**

**Written Comments from the American Economic Liberties Project, Alliance of Independent Dentists, Diatom Advisory, Pharmacists United for Truth and Transparency, and Physicians Against Drug Shortages**

**Aug. 17, 2026**

## Introduction & Summary

The American Economic Liberties Project (AELP),[1] the Alliance of Independent Dentists,[2] Diatom Advisory,[3] Pharmacists United for Truth and Transparency,[4] and Physicians Against Drug Shortages[5] submit these written comments in response to the Senate Democrats' request for information (RFI) regarding "Commonsense Policy Options to Lower Drug Prices for Patients."[6]

We appreciate the Senate Finance Committee's efforts to lower drug prices in the United States. To achieve this goal, the committee must address the structural root causes of high prescription drug prices and stagnant innovation in the United States. These causes include decades of neoliberal policy choices that enabled the rise of Big Medicine — including private insurance conglomerates, pharmaceutical middlemen, and Big Pharma — and the offshoring of generic drug manufacturing, especially to China, at the expense of everyday Americans.

However, we worry the policy options presented in the RFI are too incremental in nature and limited in scope. For these reasons, we urge Senate Democrats to advance the following

[1] AELP is a nonpartisan, nonprofit research and advocacy organization dedicated to understanding and addressing the problem of concentrated economic power in the United States.
[2] The Alliance of Independent Dentists is a nationwide group of volunteer dentists committed to educating dentists and the public about the benefits of independent dentistry.
[3] Diatom Advisory is an independent employee benefits firm in Oklahoma City, Oklahoma.
[4] Founded by independent pharmacists, Pharmacists United for Truth and Transparency is a nonprofit advocacy organization that works to expose and end the harmful, anticompetitive practices of vertically-integrated pharmacy benefit managers.
[5] Physicians Against Drug Shortages' mission is to end chronic generic drug shortages by restoring competition and integrity to the broken health care supply chain via congressional repeal of the ill-conceived 1987 Medicare anti-kickback "safe harbor" for hospital group purchasing organizations.
[6] "Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients," Senate Finance Committee Minority Staff, June 16, 2026, https://www.finance.senate.gov/imo/media/doc/061626_sfc_drug_pricing_rfi.pdf.

structural reforms, which would lower prescription drug prices in all markets while reducing U.S. pharmaceutical dependence on China, which threatens both public health and national security. Recent polling shows there is strong bipartisan support among U.S. voters for our proposals.[7]

In addition, we submit the attached AELP reports — "Ban Prior Authorization: Ending Big Medicine's Strategy to Boost Profits by Denying Medically Necessary Care" and "Making Medicine in America Again: Why Breaking Monopolies Is Key to Building a Resilient U.S. Pharmaceutical Manufacturing Base" — which provide more detailed background information and policy proposals.

## I. Lowering Drug Prices

Senate Democrats should break up Big Medicine — including insurance conglomerates, pharmaceutical middlemen, and Big Pharma — and eliminate the price-setting function of PBMs. Pending these reforms, Senate Democrats should enhance Medicare inflation rebates, which largely resolved the insulin affordability crisis of the 2010s. Each of these policy proposals will lower drug prices in all markets by reducing Big Medicine administrative bloat, leveraging the buying power of the federal government, and disincentivizing manufacturer price gouging, respectively.

### A. Break Up Big Medicine

Senate Democrats should support the bipartisan Break Up Big Medicine Act (S. 3822) by Sens. Elizabeth Warren (D-MA) and Josh Hawley (R-MO), which would prohibit insurers, PBMs, and wholesale drug distributors from owning or controlling health care providers, including pharmacies.[8] Insurance conglomerates and their affiliated PBMs vastly overpay their affiliated pharmacies — by up to 16,510% more than competitors[9] — to game federal regulations meant to cap profits. Their gain comes at the expense of consumers and independent pharmacies.[10] Indeed,

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[7] Findings are based on an online survey of 1,001 registered voters conducted by YouGov on June 10-12, 2026, for the American Economic Liberties Project. The survey was weighted to be representative of the national registered voter population. The margin of error is 3.9%. Detailed polling memo forthcoming.
[8] "S. 3822 — Break Up Big Medicine Act," Library of Congress, accessed Aug. 10, 2026, https://www.congress.gov/bill/119th-congress/senate-bill/3822/text.
[9] "Report on Audit of Caremark," State of Tennessee Department of Commerce and Insurance, Jan. 22, 2026, https://tnpharm.org/wp-content/uploads/CaremarkReportAuditPackage_20260212.pdf.
[10] "Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street
Pharmacies," Federal Trade Commission, July 2024,
https://www.ftc.gov/news-events/news/press-releases/2024/07/ftc-releases-interim-staff-report-prescription-drug-middlemen.

research conservatively estimates that the divestiture of vertically integrated pharmacies would reduce drug costs by more than 7%.[11]

Senate Democrats should also advance legislation to prohibit PBM ownership of private labelers. Each of the "Big Three" PBMs or their parent companies have recently established offshore private labelers that partner with manufacturers to distribute biosimilar drugs under new names.[12] This arrangement creates several potential revenue streams, including "increased earnings from biosimilar manufacture, discounted prices for PBM-affiliated specialty pharmacies, increased prices for non-affiliated pharmacies, assurance of supply, and bargaining leverage in negotiations with biosimilar manufacturers," according to a July 2024 report by the Federal Trade Commission.[13]

For instance, in 2023, CVS Health's private labeler, Cordavis, began distributing Hyrimoz, a biosimilar of Humira, the world's best-selling brand-name drug, after Humira's patent expired.[14] CVS Health's PBM, Caremark, replaced Humira with Hyrimoz on its formularies, ensuring continued demand while deflecting criticism that it was favoring high-cost, brand-name drugs for their correspondingly high rebates over lower-cost biosimilars.[15] Although Hyrimoz's 2024 list price ($1,300) was lower than Humira's ($6,922), it was still higher than other independent biosimilar alternatives ($995), partially safeguarding CVS Health's revenue by forcing plan sponsors and members to pay more for an affiliate's product.[16]

Finally, Senate Democrats should break Big Pharma's illegal patent monopolies by introducing a companion to the Medicines for the People Act (H.R. 7854) by Rep. Rashida Tlaib (D-MI-12),[17] which would create a public option for pharmaceutical research and development.[18] Senate Democrats should also advance legislation that prohibits patent thickets, product hopping, and

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[11] Eric Yde, "Vertical Integration and Regulated Profits in Pharmacy Benefits Markets," University of Virginia Department of Economics, Oct. 14, 2025, https://www.dropbox.com/scl/fi/bgwfw0axy7sw9pozed60q/Yde_JMP.pdf?.
[12] See 9.
[13] See 9.
[14] "CVS Health launches Cordavis," CVS Health, Aug. 23, 2023, https://www.cvshealth.com/news/pbm/cvs-health-launches-cordavis.html.
[15] Rep. Katie Porter (@RepKatiePorter), "In 2023, cheaper alternatives to the drug Humira came to market...," X, July 23, 2024, https://x.com/RepKatiePorter/status/1815911555189641495.
[16] See 9; Adam Fein, "Humira Biosimilar Price War Update: Should We Be Glad that CVS Health and Express Scripts Are Using Private Label Products to Pop the Gross-to-Net Bubble?" Drug Channels, Sept. 4, 2024, https://www.drugchannels.net/2024/09/humira-biosimilar-price-war-update.html.
[17] "H.R. 7854 — Medicines for the People Act," Library of Congress, accessed Aug. 10, 2026, https://www.congress.gov/bill/119th-congress/house-bill/7854.
[18] Dana Brown, "A Public Option for Pharmaceutical R&D," Vanderbilt Policy Accelerator, February 2026, https://cdn.vanderbilt.edu/vu-URL/wp-content/uploads/sites/412/2026/01/30174311/A-Public-Option-for-Pharmaceutical-RD.pdf.

other forms of patent abuse, all of which foreclose generic competition and keep prescription drug prices high.[19]

### B. Eliminate the price-setting function of PBMs

Senate Democrats should advance legislation that standardizes prescription drug prices and formularies, essentially replacing the functions of private PBMs and thus rendering them unnecessary. The three largest PBMs — CVS Health's Caremark, Cigna's Express Scripts, and UnitedHealth Group's Optum Rx — control 80% of U.S. prescriptions and are vertically integrated with the nation's biggest private health insurers and pharmacies.[20] This business model allows them to jack up drug costs at their affiliated pharmacies while squeezing unaffiliated pharmacies out of business.[21] This is a bad deal for patients, pharmacies, employers and other health plan sponsors, and taxpayers.

Specifically, this legislation should require Medicare to negotiate all drug prices and formularies directly with manufacturers that would then apply in all markets. In conjunction with mandating a fair pharmacy reimbursement model, as discussed below, this approach would lower drug prices for all patients while ensuring the financial viability of independent pharmacies, at which many patients access care.

Notably, this approach would differ from the existing Medicare Drug Price Negotiation program, which is not only limited to a small subset of drugs in the Part D market but also leaves list prices unchanged and preserves problematic manufacturer rebates.[22] Such rebates enable price discrimination and other anticompetitive business practices that drive up consumer costs, among other harms.[23]

Under the current program, Medicare negotiates a maximum fair price for each eligible drug with its manufacturer. This maximum fair price is the basis for patient cost sharing requirements. It is also the ceiling that private Part D insurers and their affiliated PBMs can reimburse pharmacies — plus a dispensing fee —for each eligible drug prescription. However, manufacturers can still set whatever list price they want, and, in most cases, this is what

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[19] For more detailed proposals, see "The Costs of Pharma Cheating," AELP and Initiative for Medicines, Access, and Knowledge, May 2023, https://www.economicliberties.us/wp-content/uploads/2023/05/AELP_052023_PharmaCheats_Report_FINAL.pdf.
[20] See 9.
[21] See 9.
[22] The first negotiated prices for Medicare Part B drugs will take effect in 2028. Juliette Cubanski and Tricia Neuman, "Key Facts About Medicare Drug Price Negotiation," KFF, March 11, 2026, https://www.kff.org/medicare/key-facts-about-medicare-drug-price-negotiation/.
[23] See 9.

pharmacies must pay to acquire the drug.[24] Manufacturers then owe pharmacies a rebate to make up the difference between their acquisition cost and the maximum fair price for each eligible drug that they dispense to a Medicare beneficiary. However, private Part D insurers and their affiliated PBMs are not required to pay the full maximum fair price, and they often set their dispensing fees far lower than pharmacies' overhead costs, both of which can contribute to pharmacies choosing not to stock eligible drugs, further constraining beneficiaries' access to affordable prescriptions.[25]

Medicare should instead negotiate drug prices and formulary placement directly with their manufacturers in all markets. Doing so would eliminate manufacturer rebates to PBMs that inflate consumer and taxpayers costs while enabling disparate reimbursement rates that disadvantage independent pharmacies.[26] It would also essentially create a public, fee-for-service alternative to private Part D insurers and their affiliated PBMs, ensuring the federal government directly administers drug benefits to Medicare beneficiaries.

In addition, Senate Democrats should advance legislation to repeal the anti-kickback safe harbors for PBMs and other pharmaceutical middlemen, including group purchasing organizations, which allow them to exploit manufacturer rebates and other kickbacks that would otherwise constitute a felony offense.[27]

### C. Enhance Medicare inflation rebates

Pending Medicare negotiated prices and formularies that extend to all markets, we support bolstering Medicare's price gouging penalties through re-basing to 1990 and extending such penalties to commercial markets, so long as there are strict provisions to ensure that they lower drug costs for patients rather than pad Big Medicine insurance conglomerates' profits. Doing so would ensure manufacturers are disincentivized from price going in the absence of more direct government price regulation.

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[24] John Coster, "Operational and Policy Considerations in the Effectuation of Medicare's Maximum Fair Drug Prices for Part D," USC Leonard D. Schaeffer Institute for Public Policy & Government Service, Oct. 16, 2025, https://schaeffer.usc.edu/research/medicare-drug-prices-mfp-effectuation/.

[25] "NCPA to CMS: A Third of Independent Pharmacies Won't Carry Drugs in the Negotiated Price Program, and 60 Percent More are Considering Dropping Out," National Community Pharmacists Association, Jan,. 27, 2025, https://ncpa.org/newsroom/news-releases/2025/01/27/ncpa-cms-third-independent-pharmacies-wont-carry-drugs-negotiated.

[26] See 9.

[27] Philip Zweig, "White Paper: A Cost Analysis of the 1987 Medicare Anti-Kickback Safe Harbor for Group Purchasing Organizations and Pharmacy Benefit Managers," Physicians Against Drug Shortages, revised April 2, 2024, https://nebula.wsimg.com/6d8b8a93bb8e7651d4300550dfbebffc?AccessKeyId=62BC662C928C06F7384C&disposition=0&alloworigin=1.

The Inflation Reduction Act of 2022 requires manufacturers to pay inflation rebates to Medicare if they raise the list price of certain drugs faster than the rate of inflation, using 2021 — the last full year before the legislation was enacted — as a benchmark.[28] This provision draws on the Omnibus Reconciliation Act of 1990, which required manufacturers to pay inflation rebates to state Medicaid programs using 1990 as a benchmark.[29] Critically, these rebates were uncapped, meaning that, in frequent cases where manufacturers raised a drug's list price far faster than the rate of inflation, the rebate exceeded the total Medicaid payment for the drug. In other words, price-gouging manufacturers could end up owing state Medicaid programs for each drug prescription.

However, the Affordable Care Act of 2010 capped Medicaid inflation rebates, meaning that, at worst, manufacturers wouldn't make money from Medicaid sales — but they couldn't ever lose money.[30] Big Pharma quickly raised their list prices far faster than the rate of inflation, in large part to account for ever-greater rebates to PBMs.[31] In conjunction with Big Pharma patent abuse and PBM consolidation, this cap created an affordability crisis for insulin and other life-saving drugs. For instance, between 1996, when Eli Lilly launched the brand-name insulin Humalog, and 2009, its list price increased from $20.82 to $99.65 — far faster than the rate of inflation but not at a completely unchecked rate.[32] In contrast, between 2010 and 2018, Eli Lilly raised Humalog's list price from $99.65 to $274.70.[33]

The American Rescue Plan Act of 2021 eliminated the cap, effective Jan. 1, 2024, and Big Pharma manufacturers responded by slashing their list prices to avoid costly Medicaid rebates.[34] Indeed, starting in late 2023, Eli Lilly lowered Humalog's list price to $66.40, proving the efficacy of inflation rebates to lower drug prices.[35]

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[28] Laura Wreschnig, "Selected Health Provisions of the Inflation Reduction Act," Congressional Research Service, Sept. 1, 2022, https://www.congress.gov/crs-product/IF12203.
[29] Rachel Dolan, "Understanding the Medicaid Prescription Drug Rebate Program," KFF, November 2019, https://www.kff.org/wp-content/uploads/2019/11/Understanding-the-Medicaid-Prescription-Drug-Rebate-Program-updated-3.2021.pdf.
[30] Elizabeth Williams, "What Are the Implications of the Recent Elimination of the Medicaid Prescription Drug Rebate Cap?" KFF, Jan. 16, 2024, https://www.kff.org/medicaid/what-are-the-implications-of-the-recent-elimination-of-the-medicaid-prescription-drug-rebate-cap/.
[31] Stephen Murphy et al., "The Changing Insulin Affordability Landscape: Lower Out-of-Pocket Costs and Expanded Access Pathways," Office of the Assistant Secretary for Planning and Evaluation, July 20, 2026, https://aspe.hhs.gov/reports/insulin-affordability-landscape#f42.
[32] Medi-Span Wholesale Acquisition Cost (WAC) Full History for NDC 00002-7510-01 HUMALOG 100 UNIT/ML VIAL.
[33] See above.
[34] William Feldman and Benjamin Rome, "The Rise and Fall of the Insulin Pricing Bubble," *JAMA Network Open*, June 14, 2023, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806020.
[35] "Lilly Cuts Insulin Prices by 70% and Caps Patient Insulin Out-of-Pocket Costs at $35 Per Month," Eli Lilly, March 1, 2023, https://investor.lilly.com/news-releases/news-release-details/lilly-cuts-insulin-prices-70-and-caps-patient-insulin-out-pocket.

Although Big Pharma claims inflation rebates cut into their research and development budgets, their own behavior suggests otherwise.[36] For instance, Eli Lilly reported to the U.S. Senate Finance Committee that it spent $244 million on research and development related to Humalog between 2014 and 2018.[37] This amounts to less than 2% of the $14.3 billion in revenue for Humalog and less than 4% of the $6.6 billion in stock buybacks that the company reported in Forms 10-K over the same period.[38] Critically, inflation rebates only kick in when manufacturers price gouge — often by rapidly raising list prices for drugs, like Humalog, that have been on the market for years and for which they have already recouped their investment.[39]

For these reasons, we support re-basing Medicare inflation rebates to 1990 for consistency with Medicaid and extending them to all markets for maximum patient benefit. Big Pharma should not be incentivized to price gouge in any context. However, Senate Democrats must also advance legislation that ensures that Medicare Advantage and commercial insurers pass 100% of these rebates through to beneficiaries at the point of sale. Otherwise, they would function as a form of wealth transfer from Big Pharma to Big Medicine insurance conglomerates, bypassing patients altogether. Because the Lower Drug Costs for Families Act (S. 1186) by Sen. Catherine Cortez Masto (D-NV) does not meet these requirements, we cannot support it.

## II. Enhancing Prescription Drug Affordability

Senate Democrats should support ending utilization management practices and mandating a fair cost-plus pharmacy reimbursement model in all markets. These policy proposals will enhance prescription drug affordability by further curbing Big Medicine administrative bloat while ensuring the financial viability of independent pharmacies and thus patient access to high-quality, affordable care.

### A. End utilization management practices

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[36] Dana Goldman et al., "Mitigating the Inflation Reduction Act's Adverse Impacts on the Prescription Drug Market," USC Leonard D. Schaeffer Institute for Public Policy & Government Service, April 13, 2023, https://schaeffer.usc.edu/research/mitigating-the-inflation-reduction-acts-potential-adverse-impacts-on-the-prescription-drug-market/.

[37] "Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug," U.S. Senate Finance Committee, Jan. 14, 2021, https://www.finance.senate.gov/imo/media/doc/Grassley-Wyden%20Insulin%20Report%20(FINAL%201).pdf.

[38] See above; "Buybacks for Eli Lilly (LLY) 1989-2026," Ticker League, accessed Aug. 10, 2026, https://tickerleague.com/companies/LLY/buybacks.

[39] Alison Kodjak, "Prescription Drug Costs Drive By Manufacturer Price Hikes, Not Innovation," NPR, Jan. 7, 2019, https://www.npr.org/sections/health-shots/2019/01/07/682986630/prescription-drug-costs-driven-by-manufacturer-price-hikes-not-innovation; Immaculada Hernandez et al., "The Contribution Of New Product Entry Versus Existing Product Inflation In The Rising Costs of Drugs," *Health Affairs*, Jan. 7, 2019, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05147.

Big Medicine insurance conglomerates abuse utilization management practices, including prior authorization and patient cost-sharing requirements, to deter, delay, and deny medically necessary care in order to boost their own profits — with predictably tragic results.[40]

Senate Democrats should advance a federal ban on prior authorization that prohibits insurance conglomerates with a financial conflict of interest from both imposing prior authorization requirements and owning or being affiliated with an entity that adjudicates requests for coverage. Under the attached proposal, "Ban Prior Authorization," the practice would be allowed only in rare, narrow circumstances where no conflict of interest is present and where strict safeguards are in place, including a prohibition on AI-based denials. A public alternative to Part D would accomplish this in the Medicare market, but, in other markets, additional reforms are still necessary.

Similarly, Senate Democrats should advance legislation to end patient cost-sharing obligations, including deductibles and co-pays, in all markets. Research shows that cost-sharing is associated with lower utilization; worse patient outcomes, including increased mortality; and greater financial burden.[41] Recent federal laws, including the Inflation Reduction Act, and bills, including the Medicare Cost Cap Act of 2026 (S. 4886), target out-of-pocket spending for those enrolled in Medicare.[42] But cost-sharing requirements negatively affect all patients, not just older adults and people with disabilities. Eliminating these requirements would simplify payment processes and broaden access to medically necessary care.[43] The resulting administrative savings would also help offset any increase in spending on medically necessary care.

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[40] Hannah Garden-Monheit and Emma Freer, "Ban Prior Authorization: Ending Big Medicine's Strategy to Boost Profits by Denying Medically Necessary Care," AELP, August 2026, https://www.economicliberties.us/wp-content/uploads/2026/08/prior-authorization-1.pdf; Hannah Garden-Monheit, "Big Medicine profits by denying care your doctor ordered. My father paid the price." *MS NOW*, Aug. 6, 2026, https://www.ms.now/opinion/health-care-prior-authorization-medicare-medicaid.

[41] Madeline Guth et al., "Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waives," KFF, Sept. 9, 2021, https://www.kff.org/medicaid/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/; David Rabin et al., "Among Low-Income Respondents With Diabetes, High-Deductible Versus No-Deductible Insurance Sharply Reduces Medical Service Use," *Diabetes Care*, Feb. 1, 2017, https://diabetesjournals.org/care/article-abstract/40/2/239/37021/Among-Low-Income-Respondents-With-Diabetes-High?redirectedFrom=fulltext; J. Wharam et al., "Vulnerable And Less Vulnerable Women In High-Deductible Health Plans Experienced Delayed Breast Cancer Care," *Health Affairs*, March 4, 2019, https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05026; Amitabh Chandra et al., "The Health Costs of Cost-Sharing," National Bureau of Economic Research, updated February 2024, https://www.nber.org/papers/w28439.

[42] Juliette Cubanski et al., "Explaining the Prescription Drug Provisions in the Inflation Reduction Act," KFF, Jan. 24, 2023, https://www.kff.org/medicare/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/; https://www.congress.gov/bill/119th-congress/senate-bill/4886

[43] Nicole Fusco et al., "Cost-sharing and adherence, clinical outcomes, health care utilization, and costs: A systemic literature review," *Journal of Managed Care & Specialty Pharmacy*, January 2023, https://pmc.ncbi.nlm.nih.gov/articles/PMC10394195/.

### B. Mandate a fair cost-plus pharmacy reimbursement model

In conjunction with structural separation and drug list price regulation, Senate Democrats should advance legislation to mandate a cost-plus pharmacy reimbursement model for generic medicines. Doing so would not only make drug pricing more transparent and predictable but also stabilize the pharmaceutical supply chain — which has been embrittled by industry consolidation — and ensure fair payment for pharmacies.[44]

Specifically, Senate Democrats should introduce a companion to the bipartisan Pharmacists Fight Back Act (H.R. 6609, H.R. 6610) — which would benchmark reimbursement to the National Average Drug Acquisition Cost (NADAC), plus a flat dispensing fee, among other provisions — that applies in all markets.[45] The bill should also require all pharmacies to participate in monthly NADAC surveys and all states to conduct cost of dispensing surveys at least every three years to ensure accurate cost benchmarks.[46]

## III. Bolstering Pharmaceutical Innovation in the United States

In addition to creating a public option for pharmaceutical research and development, as discussed earlier, Senate Democrats must bolster pharmaceutical manufacturing in the United States as a matter of public health and national security, as the attached report, "Making Medicine in America Again: Why Breaking Monopolies Is Key to Building a Resilient U.S. Pharmaceutical Manufacturing Base," explains in detail.

In short, prescription drug affordability cannot be assured without prescription drug supply. The active pharmaceutical ingredients (APIs) needed for more than four out of five of the top 100 generic drugs prescribed have no U.S.-based manufacturing source.[47] A startling share of APIs

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[44] Sally Hubbard et al., "Making Medicine in America Again: Why Breaking Monopolies Is Key to Building a Resilient U.S. Pharmaceutical Manufacturing Base," AELP, February 2026, https://www.economicliberties.us/wp-content/uploads/2026/02/20260116-aelp-supplychain-FINAL.pdf.
[45] "H.R. 6609 — Pharmacists Fight Back in Medicare and Medicaid Act," Library of Congress, accessed Aug. 13, 2026, https://www.congress.gov/bill/119th-congress/house-bill/6609; "H.R. 6610 — Pharmacists Fight Back [in Federal Employee Health Benefit Plans Act]," Library of Congress, accessed Aug. 13, 2026, https://www.congress.gov/bill/119th-congress/house-bill/6610?hl=hr+6610&s=2&r=1.
[46] Michael Murphy and Jennifer Rodis, "Shedding light on NADAC: How pricing power influences pharmacy reimbursement," PolicyRx, June 26, 2025, https://pharmacy.osu.edu/news/shedding-light-nadac-how-pricing-power-influences-pharmacy-reimbursement.
[47] "The US Active Pharmaceutical Ingredient Infrastructure: The current state and considerations to increase US Healthcare Security," Center for Analytics and Business Insights, Aug. 1, 2021, https://apicenter.org/wp-content/uploads/2024/07/The-US-Active-Pharmaceutical-Ingredient-Infrastructure.pdf.

used worldwide originates in China, regardless of where finished medicines are produced.[48] This dependence was not inevitable and instead is the result of deliberate policy choices — including corporate-friendly trade and foreign investment policies — that prioritized short-term cost reduction over long-term resilience and national security.

For these reasons, we urge Senate Democrats to prioritize the onshoring of generic manufacturing in addition to investments in pharmaceutical innovation. Specifically, Senate Democrats should enact the antimonopoly solution set presented in the paper, including:

- Competition policies to restructure pharmaceutical markets and rein in the monopolistic middlemen that squeeze generic manufacturers out of business or force them overseas, some of which we have already discussed.

- Industrial policies to invest in and create demand for a resilient U.S. pharmaceutical manufacturer base that can withstand supply chain shocks.

- Trade policies, including strategic tariffs, to promote domestic manufacturing of essential medicines – phased in once the aforementioned reforms are underway.

For instance, the CHIPS and Science Act of 2022 provides a valuable model for supporting distributed manufacturing networks, as discussed in the paper. Likewise, Senate Democrats should ensure that government procurement and investment, including innovation subsidies, do not flow to Big Pharma manufacturers that have engaged in anti-competitive business practices or aggressive offshore tax avoidance. These companies already pocket giant sums from American patients, who pay the highest drug prices in the world.[49] American taxpayers should not further subsidize them through industrial policy to promote innovation or onshoring.

**Conclusion**

The U.S. prescription drug affordability crisis is the result of decades of deliberate policy choices that enabled the rise of Big Medicine at home and the concentration of pharmaceutical manufacturing abroad. Fortunately, Senate Democrats can end this crisis by enacting the structural policy reforms presented here, all of which break with the neoliberal paradigm and instead promote competition to lower drug prices for all patients while bolstering the pharmaceutical supply chain to ensure access. However, incremental reforms that leave this

[48] "The Role of China in the Global Generic Drug API Market," DrugPatentWatch, March 25, 2025, https://www.drugpatentwatch.com/blog/the-role-of-china-in-the-global-generic-drugapi-market/; Yangzong Huang, "U.S. Dependence on Pharmaceutical Products from China," Aug. 14, 2019, Council on Foreign Relations, https://www.cfr.org/blog/us-dependence-pharmaceutical-products-china.
[49] Andrew Mulcahy et al., "International Prescription Drug Price COmparisons," RAND, Feb. 1, 2024, https://www.rand.org/news/press/2024/02/01.html.

paradigm intact, in some or all markets, will fail to achieve the Senate Democrats' stated goals. We appreciate the opportunity to submit these comments and welcome the chance to provide additional information as the Committee continues its work on this critical issue.