List Price vs Net Price for Prescription Drugs in 2026

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Executive Summary

Many branded prescription drugs with substantial rebates have list and net prices that diverge sharply. The **list price**, formally the manufacturer's **Wholesale Acquisition Cost (WAC)**, differs from **manufacturer net revenue**—what a manufacturer retains after rebates, discounts, and fees paid to pharmacy benefit managers (PBMs), health plans, wholesalers, and pharmacies. From a payer-cost perspective, the Congressional Budget Office defines net prices as "retail prices minus any post-sale rebates or discounts" (Source: www.cbo.gov). These measures are related but not identical; the gap between list-price sales and manufacturer net revenue is commonly called the "gross-to-net bubble." As of 2026, Drug Channels Institute estimates the total value of manufacturers' gross-to-net reductions across all brand-name drugs reached **$416 billion in 2025**, up from **$356 billion in 2024**, **$334 billion in 2023**, and roughly **$204 billion in 2021** for patent-protected brands alone (Source: www.drugchannels.net) (Source: www.drugchannels.net).

A peer-reviewed JAMA analysis of 602 branded drugs found that from 2007 to 2018, list prices rose 159 percent while net prices rose only 60 percent, meaning manufacturer discounts offset an estimated 62 percent of the headline price increase (Source: pmc.ncbi.nlm.nih.gov) (Source: pmc.ncbi.nlm.nih.gov). Insulin is the starkest example: list prices for insulins rose 262 percent over the same period while net prices rose only 51 percent (Source: pmc.ncbi.nlm.nih.gov). In 2023, Eli Lilly cut Humalog's list price 70 percent, from $274.70 to $66.40 per vial, and capped patient out-of-pocket costs at $35 per month (Source: apnews.com) (Source: investor.lilly.com).

The mechanics behind the gap run through pharmacy benefit managers. The Federal Trade Commission (FTC) found that the three largest PBMs, CVS Caremark, Express Scripts, and OptumRx, together administer roughly 80 percent of prescriptions filled in the United States and processed nearly 80 percent of the 6.6 billion prescriptions dispensed in 2023 (Source: www.ftc.gov). In September 2024 the FTC sued the three largest PBMs, alleging their rebate-driven formulary system helped push Humalog's list price from $21 in 1999 to over $274 by 2017, an increase the agency called

"a staggering increase of over 1,200%" (Source: www.ftc.gov); by mid-2026 the FTC had reached settlements with Express Scripts (projected to cut patient insulin out-of-pocket costs by up to $7 billion over ten years) and with Caremark Rx, while the case against OptumRx remained pending (Source: www.ftc.gov).

Crucially, rebates rarely reach patients directly. In Medicare Part D, beneficiary cost-sharing is calculated from the plan's negotiated price paid to the dispensing pharmacy at the point of sale; manufacturer rebates and other price concessions received after that sale generally do not reduce that price unless they are passed through. GAO found that "rebates do not lower individual beneficiary payments for drugs" (Source: www.gao.gov), and beneficiary payments exceeded plan-sponsor net payments on 79 of the 100 most-rebated Part D drugs in 2021, a year in which plan sponsors collected $48.6 billion in manufacturer rebates (Source: www.gao.gov). Under the Inflation Reduction Act (IRA), Medicare's first ten negotiated "Maximum Fair Prices" took effect January 1, 2026, cutting 2023 list prices by 38 percent to 79 percent, including Eliquis ($521.00 to $231.00, a 56 percent cut) and Januvia ($527.00 to $113.00, a 79 percent cut) (Source: www.aha.org). This report examines who sets list price, how rebates are negotiated and where they flow, why the gross-to-net bubble keeps widening even as headline list-price growth slows, and what recent litigation, legislation, and Medicare negotiation mean for patients, payers, and the life-sciences organizations that must model this system.

Introduction and Background

Ask a pharmacist, an insurer, and a manufacturer what a drug "costs," and each will likely give a different number. That is not confusion; it is the design of the U.S. pharmaceutical distribution system, in which a drug's **list price** (the sticker price manufacturers set) and its **net price** (what manufacturers actually collect after rebates and discounts) have diverged so sharply that industry analysts now speak of a "gross-to-net bubble" measured in the hundreds of billions of dollars a year (Source: www.drugchannels.net). Understanding that gap, and who benefits from it, has become essential for anyone working in pharmaceutical market access, payer contracting, health policy, or life-sciences commercial operations.

The distinction matters because almost every headline about drug pricing, whether it concerns a $969-a-month diabetes drug or a lawsuit against a PBM, is a claim about one of these two numbers, and the two numbers tell very different stories. List price is what shows up in press releases and pricing databases and can be relevant to coinsurance in some benefit designs, while Medicare Part D cost-sharing is based on the plan's negotiated point-of-sale price. Net price is what actually changes hands between a manufacturer and the supply chain, after a web of rebates, chargebacks, administrative fees, and discounts, most of which are contractually confidential. Independent analysis confirms the U.S. list-price side of that equation is genuinely unusual by international standards: KFF finds that "list prices for brand-name drugs are often much higher in the U.S." than in other wealthy countries, even before accounting for how much of that list price is later rebated away (Source: www.kff.org). For life-sciences professionals, the practical stakes are not abstract. A contract that looks identical on its face, expressed purely in list-price terms, can produce very different net revenue outcomes depending on how rebate tiers, formulary placement, and channel mix are structured, which is precisely why finance, market access, and commercial operations teams increasingly track list and net price as two separate, continuously reconciled data streams rather than as a single number. As of August 2026, this opacity has become a focal point for federal antitrust enforcement, Medicare price negotiation, and state-level litigation, all colliding with a decade-long trend of double-digit list-price increases paired with much smaller, and in 2025 outright negative, net-price growth (Source: www.drugchannels.net).

This report unpacks the full mechanics of gross-to-net pricing: what WAC, Average Wholesale Price (AWP), and net price formally mean; how pharmaceutical rebates are negotiated and where they actually flow, including the PBM "spread pricing" practices under active FTC investigation; which therapeutic classes carry the steepest discounts; who ultimately captures the savings, manufacturers, PBMs, insurers, pharmacies, 340B covered entities, or patients; and what five recent, named cases, spanning insulin pricing, PBM litigation, Medicare drug negotiation, Congressional hearings, and biosimilar competition, reveal about how this system behaves in practice. Because this is a data-intensive and rapidly evolving area of health policy, life-sciences organizations frequently need external analytical and technology support to model gross-to-net scenarios, track rebate contract performance, and translate CMS and payer data into usable commercial intelligence; consultancies focused on pharmaceutical AI and data engineering, including IntuitionLabs, work specifically in this space, building analytics and reporting tools for pharmaceutical commercial operations teams navigating exactly this list-versus-net complexity (Source: intuitionlabs.ai). All figures below are anchored "as of" the dates their sources report; where sources conflict, this report notes the discrepancy rather than resolving it artificially.

Defining List Price, Net Price, and the Gross-to-Net Spread

Wholesale Acquisition Cost (WAC) is the formal, statutory term for what most people mean by "list price." Federal law defines WAC as the "manufacturer's list price for the drug or biological to wholesalers" (Source: www.law.cornell.edu), excluding any discounts or rebates. The Centers for Medicare & Medicaid Services (CMS) uses WAC-based pricing as a fallback benchmark for Medicare Part B drug reimbursement when Average Sales Price (ASP) data is unavailable, noting that "in the absence of ASP data, CMS may use the wholesale acquisition cost-based prices (WAC)" (Source:

www.cms.gov). A related, older benchmark, **Average Wholesale Price (AWP)**, is a manufacturer- or publisher-reported figure rather than an actual transaction price; the HHS Office of Inspector General (OIG) has found that reliance on AWP-based reimbursement "has caused Medicaid to pay too much for certain drugs" (Source: oig.hhs.gov). WAC is set by the manufacturer and can be changed at its discretion. AWP, however, is a reported benchmark rather than an actual transaction price. The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) confirms that "drug manufacturers may change the list prices of their drugs at any time after launch" (Source: aspe.hhs.gov), which is why many manufacturers have historically implemented list-price increases in January, even though a drug's actual, negotiated net price may move differently.

Net price, by contrast, is a derived figure rather than a posted one. The Congressional Budget Office (CBO) defines net prices as "retail prices minus any post-sale rebates or discounts" (Source: www.cbo.gov), and explains that "rebates are determined through negotiations between plans or their pharmacy benefit managers (PBMs) and manufacturers" (Source: www.cbo.gov), meaning net price varies by payer, by plan, and often by individual contract, and is rarely disclosed publicly. GAO describes Part D rebates specifically as "discounts generally paid by manufacturers to Part D plan sponsors and PBMs after the sale" (Source: www.gao.gov), which is the structural reason net price cannot simply be looked up: it is reconstructed after the fact from rebate checks, not posted at the point of sale. In one multi-year GAO analysis of Part D drugs, "net expenditures (gross expenditures less rebates and other price concessions) increased only 13 percent" over a period in which gross, list-based spending rose far faster (Source: www.gao.gov), an early illustration of the same pattern that later analyses would call the gross-to-net bubble.

That bubble has a specific, industry-recognized definition. Drug Channels Institute, the most frequently cited independent tracker of gross-to-net trends, defines it as the "ever-widening gap between brand-name drug sales at list prices and their net revenues" (Source: www.drugchannels.net), and confirms the terminology link explicitly: "the manufacturer of a drug establishes the drug's list price, called the Wholesale Acquisition Cost" (Source: www.drugchannels.net). Manufacturers themselves must account for this gap in their financial statements: Pfizer's SEC filings, for example, report a "total accrued rebates and other sales-related accruals" line item that runs into the billions of dollars (Source: www.sec.gov), a direct accounting reflection of the gross-to-net spread. Manufacturers must also sign a federal rebate agreement to have their drugs covered by Medicaid at all: the Kaiser Family Foundation (KFF) explains that "a manufacturer who wants its drug covered under Medicaid must enter into a rebate agreement" with HHS (Source: www.kff.org), meaning rebates are not optional discounting but a structural condition of market access across public payers.

The Gross-to-Net Bubble: Sizing the Gap Between List and Net Price

The dollar scale of the gross-to-net gap has grown consistently for at least five years, even as the rate of growth has recently slowed. Drug Channels Institute's year-by-year estimates, summarized in *Table 1* below, show total gross-to-net reductions for brand-name drugs climbing from roughly $204 billion for patent-protected brands in 2021 to $416 billion across all brand-name drugs in 2025.

Table 1 below summarizes Drug Channels Institute's published estimates of the total dollar value of manufacturer rebates, discounts, and fees (the gross-to-net bubble) for U.S. brand-name prescription drugs.

YEAR	TOTAL GROSS-TO-NET REDUCTIONS	SCOPE	SOURCE
2021	**$204 billion** (patent-protected brands only)	Brand-name, patent-protected	(Source: www.drugchannels.net)
2023	**$334 billion**	All brand-name drugs	(Source: www.drugchannels.net)
2024	**$356 billion** (+7% year over year)	All brand-name drugs	(Source: www.drugchannels.net)
2025	**$416 billion**	All brand-name drugs	(Source: www.drugchannels.net)

Even accounting for methodological differences between analysts, the consistent multi-year climb in these estimates underscores that gross-to-net dynamics are not a temporary artifact of any single budget cycle: rebate-driven list-price inflation has compounded for the better part of a decade, and the resulting bubble now represents a meaningful share of total U.S. brand-name pharmaceutical sales measured at list price. The 2024 total, despite setting a new dollar record, actually represented the slowest year-over-year growth rate "in at least a decade," according to Drug Channels (Source: www.drugchannels.net), and by 2025 the industry-wide pattern had shifted further: list prices for brand-name drugs grew only 3.5 percent while net prices actually declined, and inflation-adjusted net prices fell for the eighth consecutive year, dropping 3.4 percent in real terms (Source: www.drugchannels.net). On average, Drug Channels finds that rebates and discounts now "reduce the selling prices of brand-name drugs to half of their list prices" (Source: www.drugchannels.net), a figure corroborated by a PhRMA-commissioned Berkeley Research Group (BRG) study, which found that branded manufacturers "netted 63% of a med's average list price" in 2015, with total rebates and discounts rising from $67 billion in 2013 to $106 billion in 2015 (Source: www.fiercepharma.com) (Source: www.fiercepharma.com).

Independent estimates broadly agree on direction, if not magnitude. IQVIA Institute reporting, relayed by trade press, found the U.S. drug market at net manufacturer prices grew 11.4 percent in 2024, up sharply from 4.9 percent growth in 2023, while forecasting that list-price-based spending would grow 5 to 8 percent annually through 2029 versus only 3 to 6 percent net revenue growth for manufacturers, a widening, not narrowing, gap over the medium term (Source: www.fiercepharma.com) (Source: www.fiercepharma.com). PhRMA, the industry's own trade association, argues the discounting trend actually favors patients and payers: its website states plainly that "half of every dollar spent on brand medicines goes to entities that play no role in the research, development, or manufacturing of those medicines" (Source: www.phrma.org), and that net brand-medicine prices actually declined 3 percent in 2023 (Source: www.phrma.org). No single "gross-to-net gap by therapeutic class" figure is published annually by a government body, but the JAMA analysis discussed later in this report offers the most rigorous class-level evidence available, and it points squarely at insulin and diabetes medicines as the classes where the list-net divergence is most extreme.

How Rebates Flow: PBMs, Spread Pricing, and Rebate Walls

Pharmacy benefit managers sit at the center of the gross-to-net system because they, not manufacturers or patients, negotiate most commercial and Part D rebates. Three companies dominate this function. The FTC's July 2024 interim staff report found that "the top three PBMs processed nearly 80 percent of the approximately 6.6 billion prescriptions dispensed by U.S. pharmacies in 2023, while the top six PBMs processed more than 90 percent" (Source: www.ftc.gov), and a related FTC staff report found that "the Big 3 PBMs' share of claims managed increased from 70 percent in 2016 to 79 percent in 2023," with the top six PBMs managing 94 percent of all prescription drug claims nationally (Source: www.ftc.gov) (Source: www.ftc.gov). PhRMA cites the same concentration in its own advocacy, stating that "just three PBMs control 80% of the prescription drug market" (Source: www.phrma.org), and USC Schaeffer Center testimony to the House Judiciary Committee corroborated the figure independently: "three PBMs control about 80% of the market, raising concerns about limited competition and innovation" (Source: schaeffer.usc.edu). KFF's own tally arrives at a comparable figure through claims data rather than dispensing volume, finding the top three PBMs "manage 79% of prescription drug claims on behalf of 270 million people in 2023" (Source: www.kff.org), and a January 2025 lawsuit by the Massachusetts Attorney General echoed the same concentration figure while framing its consequence for formulary access, alleging that "the PBM defendants, which control 80% of the pharmacy benefit market, design and implement approved drug lists" that determine which insulin products patients can obtain (Source: www.mass.gov).

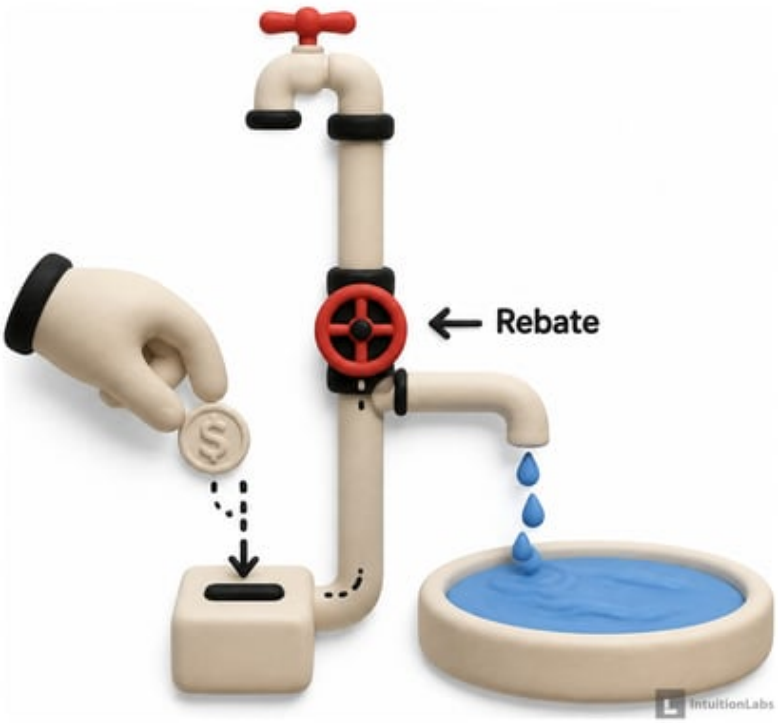
The FTC's formal description of how a rebate functions is central to understanding the gap: a manufacturer rebate is "a payment to PBMs (which may be largely or entirely passed on to health plans) in exchange for favorable formulary placement" (Source: www.ftc.gov). Because rebates are often calculated as a percentage of list price, although contract formulas can also include fixed, volume, market-share, or other terms, critics and the FTC allege that formulary arrangements structured this way can create incentives to favor larger rebates and higher list prices, a dynamic often called "rebate chasing." A separate but related practice under scrutiny is **spread pricing**, which CMS formally defines: "PBMs keep a portion of the amount paid to them by the health plans," representing the "spread between the amount that the health plan pays the PBM" and what the PBM reimburses the pharmacy (Source: www.cms.gov) (Source: www.cms.gov). GAO has separately documented state laws that specifically restrict PBMs' "ability to pay pharmacies less than they charge health plans" (Source: www.gao.gov), confirming spread pricing as a distinct, additional revenue source from rebates.

The FTC's January 2025 second interim staff report quantified self-dealing at PBM-owned pharmacies directly, finding the "Big 3 PBMs also appeared to generate significant income from spread pricing" and that they "marked up numerous specialty generic drugs dispensed at their affiliated pharmacies by thousands of percent," generating "over $7.3 billion of dispensing revenue in excess of" the National Average Drug Acquisition Cost (NADAC) benchmark between 2017 and 2022 (Source: www.ftc.gov) (Source: www.ftc.gov). The FTC's July 2024 report separately found "nearly $1.6 billion in excess revenue on just two cancer drugs in under three years" flowing to PBM-affiliated specialty pharmacies (Source: www.ftc.gov), and reported that nearly 30 percent of Americans surveyed said they had rationed or skipped doses of prescribed medicines because of cost (Source: www.ftc.gov).

Beyond spread pricing, the FTC has separately studied "rebate walls," defined as a situation in which "a dominant pharmaceutical manufacturer uses rebate strategies in its contracts with third party payors to maintain market power" (Source: www.ftc.gov), a mechanism explored further in the Humira biosimilar case study below. As for how much of the rebate dollar actually reaches employer health plans, the evidence is genuinely mixed. PBM executives testified to Congress in July 2024 that 95 to 98 percent of rebates flow to employers (Source: kffhealthnews.org), and Express Scripts separately testified it "passed through over 95% of rebates it collected for its clients in 2022" (Source: www.drugchannels.net). Yet an employer-side survey cited by Drug Channels found "slightly less than 60% of employers report receiving 100% of rebates" (Source: www.drugchannels.net), a discrepancy this report notes rather than resolves. In response, federal legislation enacted in February 2026 requires PBMs serving ERISA-regulated private employer health plans to pass through 100 percent of rebates and related remuneration, but the requirement applies to contracts entered into, renewed, or extended for plan years beginning 30 months after enactment—generally 2029 for calendar-year plans. The law also delinks Medicare Part D PBM compensation from drug prices and rebate arrangements beginning in 2028 (Source: www.kff.org).

Analysis of Key Segments: Who Captures the Rebate Dollar

The most consequential fact about gross-to-net pricing for ordinary patients is that rebates are generally calculated after the point of sale, while Part D patient cost-sharing is calculated from the plan's negotiated point-of-sale price paid to the dispensing pharmacy. GAO's review of Medicare Part D found that post-sale rebates do not lower individual beneficiary payments for drugs (Source: www.gao.gov), and that for 79 of the 100 most heavily rebated Part D drugs in 2021, "payments by beneficiaries were more than plan sponsor payments, after accounting for rebates" (Source: www.gao.gov), even though plan sponsors collected $48.6 billion in rebates that year (Source: www.gao.gov). CMS has reached a closely related conclusion about Part D's broader direct and indirect remuneration (DIR) system, noting that while such payments "may hold down total program expenses (and beneficiary premiums)," they do "not reduce the cost of drugs for beneficiaries at the point-of-sale" (Source: www.cms.gov). Research from the USC Schaeffer Center published in JAMA found this dynamic worsening rapidly: the share of stand-alone Medicare Part D plans using coinsurance, a percentage of list price, rather than a flat copay for preferred brand drugs "sharply increased from 9.9% in 2020 to 71.9% in 2024" (Source: schaeffer.usc.edu). For Eliquis specifically, average expected beneficiary out-of-pocket costs in stand-alone Part D plans "more than doubled, from $46.76 to $102.32" between 2020 and 2024, even though Part D rebates on the drug averaged 45 percent (Source: schaeffer.usc.edu). Lead author Erin Trish summarized the effect bluntly: patients on highly rebated drugs end up "generating rebates that subsidize premiums for everyone else. That is the opposite of how insurance is supposed to work" (Source: schaeffer.usc.edu).



Two supply-chain arrangements deepen this dynamic. First, **copay accumulator and maximizer programs** let health plans capture the value of manufacturer copay-assistance coupons rather than credit them toward a patient's deductible: KFF explains that "the health plan reaps the vast majority of the benefit of the drug manufacturer coupon, shifting costs back to the consumer" (Source: www.kff.org). KFF's 2024 Employer Health Benefits Survey found "nearly one in five (17%) large employer-sponsored health plans have a copay accumulator program" (Source: www.kff.org), and "two-thirds (66%) of" ACA Marketplace plans in unrestricted states use such a program as of 2024 (Source: www.kff.org). Drug Channels found that by early 2026, roughly "four in ten commercially insured lives were enrolled in plans using a copay accumulator or a maximizer" (Source: www.drugchannels.net). While 20 states plus the District of Columbia restrict these programs in state-regulated plans (Source: www.kff.org), those restrictions do not reach self-funded employer plans governed by federal ERISA law, which cover the majority of the commercially insured workforce.

Second, the **340B Drug Pricing Program** creates a separate, statutory discount tier for safety-net providers, calculated as "the average manufacturer price (AMP)" minus "the unit rebate amount (URA)" (Source: www.hrsa.gov). The Congressional Research Service (CRS) reports total 340B program sales reached "approximately $44 billion, an almost 15% increase over 2020" (Source: www.congress.gov), and notes that "providers may pass the drug discounts on to patients, but the statute does not require them to do so" (Source: www.congress.gov), meaning 340B savings, like rebates elsewhere in the system, do not automatically flow to patients. The Health Resources and Services Administration (HRSA) formally determined in

2021 that Eli Lilly's restriction of 340B pricing at contract pharmacies constituted overcharging, with HRSA stating it "determined that Lilly's actions have resulted in overcharges and are in direct violation of the 340B statute" (Source: 340breport.com), backed by civil penalties of up to $5,000 "for each instance of overcharging" (Source: 340breport.com). GAO's October 2025 testimony found the number of 340B covered-entity sites has more than doubled over the past decade, noting that "the number of covered entity sites more than doubled" while HRSA has implemented only 5 of 20 outstanding GAO recommendations and now "audits 200 covered entities a year" (Source: www.gao.gov) (Source: www.gao.gov).

Taken together, these mechanisms, list-price-based coinsurance, copay accumulator programs, and discretionary 340B pass-through, share a common structural feature: each preserves a channel through which savings generated upstream in the supply chain can be retained by an intermediary rather than automatically flowing to the patient at the point of sale. That structural feature, more than any single actor's behavior, is what regulators and legislators have targeted with the reforms discussed later in this report. Manufacturers, for their part, argue the supply chain, not manufacturers, captures most of the value created by rebates. A PhRMA-commissioned BRG white paper found manufacturers retained just 49.9 percent of total 2023 brand-medicine spending, down from 66.8 percent in 2013, while 340B-related provider markups grew eighteen-fold, "from $3.5 to $64.4 billion" over the same decade (Source: cdn.aglty.io) (Source: cdn.aglty.io). PhRMA's public messaging frames the issue starkly, arguing that "insurers and PBMs get billions of dollars in rebates and discounts that can reduce the cost of brand medicines by 50% or more" while patients are still made to "pay based on the full price" (Source: www.phrma.org). Independent testimony to the Senate Judiciary Committee reached a related, if more pointed, conclusion: vertically-integrated PBM-insurer-pharmacy conglomerates "earn higher profits from their investments compared to the average firm in the S&P 500" (Source: www.judiciary.senate.gov). Congress has responded with the bipartisan DRUG (Delinking Revenue from Unfair Gouging) Act, H.R. 2214, introduced in March 2025, which would require that "a pharmacy benefit manager shall derive no remuneration from any entity for services, benefit administration" tied to a drug's price (Source: www.govinfo.gov), with sponsors describing it as a rule that "requires PBMs to only charge a flat fee for drug placement versus letting them continue to charge a percentage" of the drug's price (Source: millermeeks.house.gov).

Data Analysis and Evidence

Company-level financial disclosures offer the clearest quantitative window into how individual manufacturers experience the gross-to-net gap, because SEC filings and investor reports require companies to reconcile gross, list-based sales against net, post-rebate revenue. *Table 2* below summarizes several such disclosures for fiscal year 2025, aggregated by Drug Channels Institute from public company filings.

Table 2 below presents manufacturer-disclosed list-price and net-price trends for fiscal year 2025, illustrating how individual companies experienced the industry-wide gross-to-net gap.

COMPANY	DISCLOSED METRIC (2025)	PRIOR-YEAR COMPARISON	SOURCE
Sanofi	Rebate share of gross U.S. sales fell to 39%	Down from 51% in 2020	(Source: www.drugchannels.net)
Sanofi	U.S. sales grew $10.8 billion (+76%) 2020 to 2025	Total rebate payments grew only $1.5 billion (+10%) over the same span	(Source: www.drugchannels.net)
Bristol Myers Squibb	Average discount from list price widened to roughly 53%	From roughly 49% in 2024	(Source: www.drugchannels.net)
Pfizer	Portfolio average net price fell approximately 2% (approximately 5% excluding COVID-19 products)	Reported in Pfizer's 2025 Impact Report	(Source: www.drugchannels.net)
Novo Nordisk	Average U.S. prices after rebates declined in 2025	Disclosed in Form 20-F	(Source: www.drugchannels.net)
Industry aggregate (8 large manufacturers)	Average list-to-net gap of roughly negative 5.5%	Reflecting average list growth of about 3.7% offset by net decline	(Source: www.drugchannels.net)

Novo Nordisk's own SEC-filed reconciliation illustrates the scale involved for a single large manufacturer: global gross sales of DKK 729,423 million against net sales of DKK 309,064 million in fiscal 2025, with U.S. rebates, discounts, and sales returns alone reaching DKK 394,631 million, up from DKK 357,928 million in 2023 (Source: www.sec.gov). Interpreted together, *Table 2* shows a consistent pattern across manufacturers of different sizes and therapeutic focuses: list prices in 2025 grew modestly if at all, net prices flat to declining, and rebate obligations as a share of gross sales generally stable or shrinking slightly, a pattern consistent with heightened pricing scrutiny, biosimilar and generic competition, and payer leverage rather than manufacturers unilaterally reducing sticker prices.

The clearest peer-reviewed evidence on the historical divergence between list and net price comes from a JAMA-published analysis of 602 branded drugs, which found that from 2007 to 2018, "list prices increased by 159% and net prices increased by 60%" across the sample, with discounts offsetting an estimated 62 percent of the headline list-price increase (Source: pmc.ncbi.nlm.nih.gov) (Source: pmc.ncbi.nlm.nih.gov). The study's therapeutic-class breakdown found the gap most extreme for insulins, where list prices climbed 262 percent against a 51 percent net-price rise (Source: pmc.ncbi.nlm.nih.gov), and found Medicaid-specific discounts rose from 40 percent in 2007 to 76 percent in 2018 (Source: pmc.ncbi.nlm.nih.gov). This convergence across a peer-reviewed clinical drug sample, an industry-funded supply-chain study, and individual manufacturer SEC filings is notable precisely because the three source types have different incentives to shade their numbers in different directions: academic researchers have no direct financial stake in the outcome, PhRMA-funded analyses have an incentive to emphasize how much of list price manufacturers surrender to the supply chain, and SEC filings are subject to securities-law accuracy requirements that make outright misstatement legally risky. That three structurally different evidentiary paths arrive at a broadly similar picture, list prices rising faster than net prices for well over a decade, is one of the more robust empirical findings in the drug-pricing literature. More recently, Drug Channels found that GLP-1 agonist nominal net prices, the class that includes Ozempic and Wegovy, "fell by more than 34% during the first three quarters of 2025" even as total spending rose on higher utilization (Source: www.drugchannels.net), a period in which Eli Lilly, Novo Nordisk, and Sanofi also collectively reduced insulin list prices by roughly 50 to 80 percent on products that previously generated over $20 billion in gross sales, per the same Drug Channels analysis. Taken together, this quantitative evidence supports a consistent conclusion: the gross-to-net gap is not a marginal accounting footnote but a multi-hundred-billion-dollar structural feature of U.S. drug pricing, concentrated most heavily in insulin, diabetes, and GLP-1 medicines, and it persists even in years when headline list-price inflation slows.

Case Studies and Real-World Examples

Eli Lilly's 2023 Insulin List-Price Cuts

In March 2023, Eli Lilly announced it would cut list prices for its most commonly prescribed insulins and cap patient out-of-pocket costs, under the headline "Lilly Cuts Insulin Prices by 70% and Caps Patient Insulin Out-of-Pocket Costs at $35 Per Month" (Source: investor.lilly.com). The Associated Press reported the specific dollar mechanics: a 10-milliliter vial of Humalog would fall in list price "from $274.70" to "$66.40," and the "same amount of Humulin currently lists at $148.70" would fall "to $44.61" (Source: apnews.com) (Source: apnews.com). What makes the case a useful illustration of the list-versus-net dynamic is Lilly's own acknowledgment of why the cuts were framed around list price at all: the AP reported that "discounts Lilly offers from its list prices often don't reach patients through insurers or pharmacy benefit managers" (Source: apnews.com), meaning the company judged that cutting the list price itself, not just offering a bigger rebate, was the only reliable way to lower what cash-paying and high-deductible patients actually paid at the pharmacy counter.

FTC v. Caremark, Express Scripts, and OptumRx (Insulin Pricing)

In September 2024 the FTC filed an administrative complaint against the three largest PBMs, alleging their rebate-driven negotiating practices contributed to artificially inflated insulin list prices. The complaint documented that the average list price of Humalog "was only $21" in 1999, but that "by 2017, the list price of Humalog soared to more than $274," an increase the agency called "a staggering increase of over 1,200%" (Source: www.ftc.gov). An FTC official described the three PBMs as "medication gatekeepers" who "have extracted millions of dollars" from vulnerable insulin patients (Source: www.ftc.gov), and the complaint asserted that "PBMs keep hundreds of millions of dollars in rebates and fees each year and use rebates to attract clients" (Source: www.ftc.gov), naming the "Big Three" PBMs, which "together administer about 80% of all prescriptions" (Source: www.ftc.gov). By February 2026, the FTC had reached a settlement with Express Scripts projected to "drive down patients' out-of-pocket costs for drugs like insulin by up to $7 billion over 10 years" (Source: www.ftc.gov), and by July 2026 had reached a second settlement with Caremark Rx and its Zinc Health Services group purchasing entity (Source: www.ftc.gov). As of this report's August 2026 publication date, the matter against OptumRx remains pending, with the FTC having filed a "Joint Motion to Withdraw Matter From Adjudication" in June 2026 while considering a proposed consent agreement (Source: www.ftc.gov), meaning the case remains an active, unresolved test of federal PBM enforcement.

Medicare Drug Price Negotiation Under the Inflation Reduction Act

CMS announced the first ten drugs selected for Medicare price negotiation on August 29, 2023, in what CMS Administrator Chiquita Brooks-LaSure called "a significant and historic moment for the Medicare program" (Source: www.cms.gov). Negotiations concluded on "August 1, 2024," with negotiated "Maximum Fair Prices" taking effect January 1, 2026 (Source: www.cms.gov). CMS's own fact sheet shows the resulting discounts off 2023 list prices ranged from 38 percent to 79 percent across the ten drugs, per trade-press summary (Source: www.aha.org), with Eliquis falling from a $521.00 list price to a $231.00 negotiated price (a 56 percent cut) and Januvia falling from $527.00 to $113.00 (a 79 percent cut), the largest reduction among the initial ten drugs (Source: www.cms.gov). CMS estimated that had these negotiated prices applied in 2023, they "would have saved an estimated $6 billion in net covered prescription drug costs," roughly 22 percent below what net spending on the same drugs actually was (Source: www.cms.gov). A second round, announced January 17, 2025, added 15 more drugs including Ozempic, Rybelsus, and Wegovy (Source: www.nbcnews.com), together accounting for "about $41 billion in total gross covered prescription drug costs" (Source: www.cms.gov), with negotiated prices for round two scheduled to take effect in 2027. Maximum Fair Prices are Medicare-specific negotiated prices for selected drugs. The statutory ceiling is the lesser of a Part D weighted-average price net of rebates and discounts (or the applicable Part B benchmark) and an inflation-adjusted percentage of the 2021 non-Federal Average Manufacturer Price; this does not by itself establish a general reduction in the list-to-net spread or patient prices outside the program.

The Senate HELP Committee and the Ozempic Pricing Hearing

On February 8, 2024, the Senate Health, Education, Labor, and Pensions (HELP) Committee, chaired by Bernie Sanders, convened a hearing titled "Why Does the United States Pay, By Far, the Highest Prices in the World for Prescription Drugs?" (Source: www.congress.gov), at which Sanders confronted pharmaceutical CEOs directly, telling Merck's chief executive, "you made $52 million in total compensation in 2022" (Source: www.fiercepharma.com). A follow-up September 24, 2024 HELP Committee report focused specifically on Novo Nordisk's GLP-1 pricing, finding that "Novo Nordisk charges Americans with Type 2 diabetes $969 a month for Ozempic," compared with "just $59 in Germany, $71 in France, $122 in Denmark, and $155 in Canada" for the identical drug (Source: www.help.senate.gov) (Source: www.help.senate.gov). Notably, the same report undercut manufacturers' longstanding argument that cutting list prices would trigger worse PBM formulary treatment: Cigna's Express Scripts told the committee that lowering Ozempic's and Wegovy's list price to match their net cost "would not result in less favorable formulary placement" (Source: www.help.senate.gov), directly contradicting the "rebate wall" rationale manufacturers frequently cite for keeping list prices high.

Ohio's PBM Spread-Pricing Litigation and Humira Biosimilar Competition

Two additional cases round out the picture at the state and product level. Ohio Attorney General Dave Yost sued OptumRx in March 2019 in Franklin County Common Pleas Court, alleging OptumRx caused "nearly $16 million in overcharges to the fund intended to protect injured workers" by failing to pass through contractually agreed drug discounts to the state's workers' compensation bureau (Source: www.ohioattorneygeneral.gov). In October 2022, OptumRx agreed to repay the state $15 million, part of over $100 million in cumulative PBM-related recoveries the state has secured (Source: www.ohioattorneygeneral.gov). Separately, when a low-list-price biosimilar of AbbVie's Humira, Yusimry, launched "at $569.27 plus dispensing cost, more than 90% below adalimumab's WAC," it initially struggled for uptake because PBM formularies continued favoring rebate-heavy, higher-list-price alternatives, a real-world illustration of a rebate wall in action (Source: www.pharmacytimes.com). That changed sharply in early 2024, when CVS Caremark gave adalimumab biosimilars outright formulary preference: biosimilar "market share among patients subject to the CVS Caremark formulary jumped from 5% to 36%" within a single week (Source: www.pharmacytimes.com), and by September 2024 Cigna's Express Scripts had followed suit, moving to "remove Humira from its largest commercial formulary in favor of multiple biosimilars" (Source: www.drugchannels.net). The Humira case shows that formulary changes can move biosimilar market share rapidly within a PBM's covered population. It does not, by itself, establish that PBMs generally choose between low-net-price and high-rebate alternatives in the same way across the market.

Implications and Future Directions

The evidence assembled here points toward a system in transition rather than a stable equilibrium. Federal enforcement has moved from investigation to settlement: the FTC's insulin case against the three largest PBMs has already produced two settlements projected to save billions of dollars in patient out-of-pocket costs, with the OptumRx matter still pending as of August 2026 (Source: www.ftc.gov). Legislatively, the February 2026 law will require 100 percent rebate pass-through for PBMs serving ERISA-regulated private employer health plans beginning with applicable contracts for plan years starting 30 months after enactment, while the pending DRUG Act would target PBM compensation tied to a drug's price (Source: www.kff.org) (Source: www.govinfo.gov). These changes do not yet delink percentage-of-price compensation across commercial markets generally; their effects will depend on the provisions' scope, implementation, and enforcement. Copay accumulator restrictions likewise remain uneven, applying in 20 states plus DC while generally not reaching self-funded ERISA plans (Source: www.kff.org).

Medicare drug price negotiation is the clearest near-term mechanism actually compressing the gross-to-net gap for specific high-volume drugs, and its scope will expand: round two negotiated prices for Ozempic, Wegovy, and 13 other drugs take effect in 2027, following the same pattern of 38 to 79 percent discounts observed in round one (Source: www.cms.gov) (Source: www.aha.org). At the same time, insulin and GLP-1 pricing trends suggest list-price cuts, not just rebates, are becoming a competitive strategy in categories with intense biosimilar or multi-manufacturer competition, as both the Lilly insulin case and the Humira biosimilar formulary shift demonstrate. Readers evaluating any single company's or program's claims about savings should therefore ask a consistent question: is the figure being cited a list-price reduction, a net-price reduction, or a reduction in what a specific payer or patient population actually pays. The case studies in this report show that these three figures can move independently of one another, sometimes in opposite directions within the same calendar year, which is precisely why treating list price and net price interchangeably continues to produce misleading headlines on both sides of the policy debate. For life-sciences commercial, market access, and pricing teams, the practical implication is that gross-to-net modeling, tracking rebate contract performance across dozens of payers, forecasting how list-price decisions ripple through 340B ceiling prices, Medicaid Best Price, and Medicare negotiated prices simultaneously, has become a genuinely complex, data-intensive discipline, one where specialized analytics and AI-enabled reporting tools are increasingly used to keep pace with shifting payer and regulatory requirements (Source: intuitionlabs.ai). Whether current reforms ultimately narrow Drug Channels Institute's estimated $416 billion gross-to-net bubble or simply redistribute it among a slightly different set of intermediaries remains, as of this report's publication, an open empirical question. It will depend heavily on implementation and enforcement: the Medicare Part D delinking provision begins in 2028, while the ERISA employer-plan rebate-pass-through requirement applies later, for plan years beginning 30 months after enactment.

Frequently Asked Questions (FAQs)

What is gross-to-net pricing in pharma? Gross-to-net pricing describes the accounting bridge between a drug's gross, list-price-based sales and its net, post-rebate revenue. Drug Channels Institute defines the resulting "gross-to-net bubble" as the "ever-widening gap between brand-name drug sales at list prices and their net revenues" (Source: www.drugchannels.net), which reached an estimated $416 billion across all brand-name drugs in 2025 (Source: www.drugchannels.net).

What are pharmaceutical rebates and discounts, explained simply? A rebate is a payment a manufacturer makes, typically to a PBM or health plan, after a sale has occurred, calculated as a percentage of the drug's list price, in exchange for favorable insurance coverage or formulary placement, as CBO and the FTC both describe (Source: www.cbo.gov) (Source: www.ftc.gov). A discount reduces the price more directly, such as a 340B or Medicaid statutory discount.

Where do prescription drug rebates go? Primarily to PBMs and health plans, and from there, according to PBM executive testimony, mostly (95 to 98 percent) back to the employer or plan sponsor that hired the PBM (Source: kffhealthnews.org), though independent employer surveys suggest actual pass-through may be somewhat lower in practice (Source: www.drugchannels.net). Critically, rebates reduce what plans and employers pay in aggregate, not what individual patients pay at the pharmacy counter, since GAO confirms patient cost-sharing is calculated on the pre-rebate, gross price (Source: www.gao.gov).

What is PBM spread pricing? CMS defines it as the practice by which "PBMs keep a portion of the amount paid to them by the health plans" rather than passing the full amount to the dispensing pharmacy, retaining the "spread" as revenue (Source: www.cms.gov). This is distinct from rebates and has separately drawn FTC scrutiny.

Does the gross-to-net gap vary by therapeutic class? Yes, substantially. The most rigorous class-level data, from a JAMA study of 602 branded drugs (2007 to 2018), found insulins carried the widest gap, with list prices up 262 percent against net prices up only 51 percent (Source: pmc.ncbi.nlm.nih.gov), while GLP-1 agonist net prices fell over 34 percent in the first three quarters of 2025 alone amid intense payer and manufacturer competition (Source: www.drugchannels.net).

Who ultimately captures pharmaceutical rebate savings? The evidence here is genuinely contested. PhRMA-commissioned analysis argues manufacturers retain under half (49.9 percent) of total brand-medicine spending, with PBMs, insurers, pharmacies, and 340B providers capturing the rest (Source: cdn.aglty.io), while PBMs maintain that the vast majority of rebates they collect are passed back to employers and plans (Source: www.drugchannels.net). What is not contested is that patients paying list-price-based coinsurance, and plans using copay accumulator programs, frequently see little or none of the rebate value directly (Source: schaeffer.usc.edu) (Source: www.kff.org).

Conclusion

List price and net price answer two different questions, and conflating them is the single most common source of confusion in U.S. drug pricing debates. List price, the manufacturer-set Wholesale Acquisition Cost, is what shows up in headlines and sets the baseline for 340B and Medicaid statutory discounts; it can also affect coinsurance in some benefit designs. In Medicare Part D, beneficiary cost-sharing is based on the plan's negotiated point-of-sale price. Net price, the far more consequential number for manufacturer revenue and payer spending, is a negotiated, largely confidential figure that can run 40 to 60 percent below list, reconstructed only after rebates, discounts, and fees are paid out across a multi-layered supply chain of PBMs, wholesalers, pharmacies, and health plans.

The magnitude of that gap, an estimated $416 billion across all brand-name drugs in 2025 alone, is no longer a peripheral industry statistic; it is relevant to active FTC litigation against the nation's three largest PBMs, Medicare's Inflation Reduction Act price-negotiation program, and recent federal PBM-reform legislation. The insulin, Humira biosimilar, and Medicare negotiation case studies show that list price, net price, and patient out-of-pocket cost can respond differently to rebate arrangements, formulary decisions, competition, and regulation. FTC allegations and critics of percentage-of-list-price rebate arrangements contend that those arrangements can create incentives favoring higher list prices; the extent of that effect across the market remains an empirical question. Maximum Fair Prices are negotiated Medicare prices for selected drugs, not evidence that the program generally narrows the list-to-net spread or lowers prices outside its scope. Readers should come away from this analysis with a working checklist: when encountering a drug-pricing claim, first identify whether it describes list price, net price, or patient out-of-pocket cost; then identify who set the number and what incentive they had in setting it; and treat any claim that conflates the three as, at minimum, incomplete. For manufacturers, payers, and the life-sciences organizations and consultancies that support them, the durable takeaway is that list price and net price must be modeled, reported, and explained as two related but genuinely distinct figures, not as interchangeable shorthand for what a drug "costs."

Tags: list price vs net price, gross-to-net bubble, pharmaceutical rebates, PBM spread pricing, wholesale acquisition cost, drug pricing transparency, pharmacy benefit managers, medicare drug price negotiation, 340b drug pricing, net price prescription drugs

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