

Open Payments 2026: Pharma Payments to Physicians by Company

Published August 1, 2026 34 min read



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Executive Summary

The **Centers for Medicare & Medicaid Services (CMS)** publishes the **Open Payments** database, the federal "Sunshine Act" registry that discloses financial relationships between drug and device manufacturers and the clinicians who prescribe or use their products. In June 2026, CMS published **Program Year 2025** data covering **17.07 million records worth \$14.67 billion** (Source: openpaymentsdata.cms.gov), the highest annual total since the program began collecting data in 2013 under Section 6002 of the Affordable Care Act. Trade press covering the release called it a "**record \$14.67 billion**" in payments to providers and teaching hospitals (Source: www.healthcare-brew.com), noting that roughly **\$9.5 billion of that total went toward research funding** rather than marketing (Source: www.healthcare-brew.com).

Open Payments sorts disclosures into three legally defined categories: General Payments (consulting fees, speaking honoraria, meals, travel, royalties, and gifts not tied to research), [Research Payments \(funds connected to a formal clinical study or protocol\)](#), and Ownership and Investment Interests (equity stakes held by physicians or immediate family in a reporting company). Ranking companies is not something CMS itself publishes as a table; it requires querying the raw dataset or relying on independent analyses. A 2026 MedScout analysis reported by Medscape found **BioNTech** reporting the largest single-company total, **\$536.4 million**, more than double second-place **AbbVie** (Source: www.medscape.com), a figure driven almost entirely by one large royalty payment reclassified as "not product-related," not routine marketing (Source: www.medscape.com). A year earlier, STAT News found **AbbVie** led all pharmaceutical companies in Program Year 2023 marketing-related payments at roughly **\$145.7 million**, the largest such total on record at that time (Source: www.statnews.com); a decade earlier still, MedCity News reported that **Novartis** topped the list in 2015, the program's second full year, at **\$540 million** (Source: medcitynews.com).

Medical device manufacturers show a structurally different payment profile dominated by royalty and ownership payments to physician-inventors. A peer-reviewed analysis found \$1.6 billion flowed to 28,475 orthopedic surgeons from 2014-2019 (Source: pmc.ncbi.nlm.nih.gov), and a JAMA analysis of the full 2013-2022 decade found orthopedic surgeons received the single largest specialty total of any medical field, **\$1.36 billion** (Source:

[pmc.ncbi.nlm.nih.gov](https://pubmed.ncbi.nlm.nih.gov)). Becker's Spine Review found the five largest orthopedic-focused device makers paid a combined **\$456.5 million** to physicians in a single recent year (Source: www.beckersspine.com), and KFF Health News documented more than \$3.1 billion flowing from device makers to orthopedic and spine surgeons over roughly the same 2013-2019 period, including surgeon ownership stakes in more than 200 private device companies (Source: kffhealthnews.org).

State-level data shows concentration in populous states, with California and New York leading the country in disclosed general payments to physicians, a pattern this report quantifies in detail below. Research using the database has documented real-world consequences: a 2018 JAMA Internal Medicine study linked opioid-related industry payments to a 9.3 percent increase in subsequent opioid prescribing (Source: www.eurekalert.org), and Open Payments-adjacent evidence has repeatedly featured in federal and state enforcement: Biogen's \$900 million False Claims Act settlement over speaker-program kickbacks in 2022 (Source: www.justice.gov), Pfizer/Biohaven's \$59.7 million settlement in January 2025 (Source: www.justice.gov), Reuters' report of Gilead Sciences' \$202 million settlement in April 2025 (Source: www.reuters.com), and Texas's February 2026 lawsuit against Sanofi over provider programs the state alleges "amounted to bribes" (Source: www.reuters.com). This report walks through how the database is structured, how to search it, which companies and specialties dominate disclosed spending, how the United States compares internationally, and what independent research and enforcement actions reveal about the program's real-world impact.

Introduction and Background

The **Physician Payments Sunshine Act**, codified as Section 6002 of the Patient Protection and Affordable Care Act (Public Law 111-148), created the legal foundation for what is now the Open Payments program, which CMS's original 2013 fact sheet framed around a transparency goal: giving patients, researchers, and regulators visibility into the financial ties between industry and the clinicians who prescribe drugs and use medical devices (Source: www.cms.gov). CMS, the federal agency also responsible for Medicare and Medicaid, administers the program and describes it as **"a publicly accessible database of payments that reporting entities"** make to the clinicians and institutions covered by the rule (Source: www.cms.gov).

The program's first data release, covering only August through December of 2013, arrived on September 30, 2014, and disclosed **4.4 million payments worth nearly \$3.5 billion** attributable to about 546,000 individual physicians and 1,360 teaching hospitals (Source: www.cms.gov). A dozen reporting cycles later, the June 2026 publication of Program Year 2025 data disclosed 17.07 million records amounting to \$14.67 billion, as detailed in the Executive Summary above, a more than fourfold increase in disclosed dollar volume over roughly a decade. CMS is legally obligated to publish this data on or before June 30 of each year and to refresh it again the following January to incorporate corrections, with the next scheduled refresh set for January 2027 (both facts are detailed in the FAQ section below).

"Applicable manufacturers" under the rule are entities operating in the United States that produce a covered drug, device, biological, or medical supply, while "applicable group purchasing organizations" negotiate purchases of those products on behalf of members. Both types of entities must report annually. The recipient side of the ledger has broadened over time. Covered recipients originally meant physicians and teaching hospitals; the 2018 SUPPORT for Patients and Communities Act, aimed at combating the opioid crisis, directed CMS to expand that definition, effective for data collected starting in calendar year 2021 and first published in 2022, to add five categories of **non-physician practitioners (NPPs)**: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists (and anesthesiologist assistants), and certified nurse midwives (Source: www.cms.gov). The June 2026 publication marks the fourth year that Open Payments data has included these non-physician practitioners (Source: openpaymentsdata.cms.gov).

For life-sciences organizations, Open Payments has grown from a compliance obligation into a data asset that commercial, medical affairs, and compliance functions increasingly analyze at scale to manage key-opinion-leader relationships and monitor exposure before regulators or journalists do. Consultancies serving the sector, including IntuitionLabs, offer AI-driven analytics tools built for this kind of task: the firm's **KOL Segmentation** solution is described as **"Advanced analytics for identifying and engaging key opinion leaders"** (Source: intuitionlabs.ai), and its broader analytics offering emphasizes **"Built-in compliance features"** designed to ensure that commercial activities **"meet industry standards and documentation requirements"** (Source: intuitionlabs.ai), an application area directly adjacent to Sunshine Act reporting hygiene. The remainder of this report examines how the database is structured, how to search it, which companies and medical specialties dominate disclosed spending, how the United States regime compares internationally, and what independent research and enforcement actions reveal about the program's real-world impact.

Understanding Open Payments: Categories, Recipients, and Reporting Rules

Open Payments organizes every disclosed transaction into one of three legally defined categories, and understanding the distinction is essential to interpreting any company- or specialty-level total.

General Payments are, in CMS's own words, "**Payments or transfers of value that are not in connection with a research agreement**" (Source: www.cms.gov). This category breaks down into specific "nature of payment" sub-types. **Consulting Fee** covers "**a payment that a company makes to a physician for advice and expertise**" about a product or treatment (Source: www.cms.gov). **Royalty or License** payments are "**based on sales of products that use a physician's intellectual property**" (Source: www.cms.gov), a category that, as later sections show, dominates device-industry disclosures. Other General Payment sub-types include honoraria for brief, one-time engagements, travel and lodging, gifts, food and beverage, and charitable contributions made to tax-exempt organizations rather than to individuals.

Research Payments, by contrast, are "**payments or transfers of value made in connection with a formal research agreement or research protocol**" (Source: www.cms.gov), a category that can include the time a physician spends enrolling patients in industry-funded studies. Critically, Research Payments can also be reported against a research institution rather than an individual clinician, when the covered recipient is simply named as the study's principal investigator, which explains why research payments tend to appear in far larger individual transaction sizes than routine general payments.

The third category, **Ownership and Investment Interests**, covers equity or debt stakes held by physicians or immediate family members in a reporting manufacturer or GPO, and CMS explicitly notes that "**this category is not applicable to non-physician practitioner covered recipients or teaching hospital covered recipients**" (Source: www.cms.gov). As later sections discuss, this category is concentrated overwhelmingly among physicians in device-heavy specialties such as orthopedic surgery.

Covered recipients under the program include physicians, the five categories of non-physician practitioners added in 2021, and teaching hospitals. Before any of this data reaches the public, covered recipients get a structured opportunity to review and dispute records tied to their name: CMS runs an annual **45-day pre-publication review and dispute window from April 1 through May 15**, followed by an additional 15-day correction period from May 15 to May 30 during which reporting entities can fix disputed records, and CMS itself does not mediate these disputes (Source: www.cms.gov). Non-compliant reporting entities face real financial exposure: under 42 C.F.R. § 403.912, an unknowing failure to report carries a civil monetary penalty of "**not less than \$1,000, but not more than \$10,000**" per unreported payment, while a knowing failure escalates to "**not less than \$10,000, but not more than \$100,000**" per transfer of value (Source: www.ecfr.gov) (Source: www.ecfr.gov), with aggregate annual penalties for knowing violations capped at **\$1,000,000** per entity, adjusted annually for inflation (Source: www.ecfr.gov). Reporting entities must also retain underlying records for several years after publication to support potential audits.

How to Search the CMS Open Payments Database

For anyone trying to look up a specific physician, hospital, or company, CMS provides a free, public **Open Payments Search Tool** hosted at openpaymentsdata.cms.gov. The tool allows users to search "**for physicians, physician assistants, advanced practice**" nurses and other covered recipients, and separately, "**to search drug and medical device companies to see what**" payments a given manufacturer reported, with results filterable by provider type, specialty, city, state, ZIP code, and country (Source: openpaymentsdata.cms.gov) (Source: openpaymentsdata.cms.gov).

Beyond the individual search tool, CMS maintains a more technical **Dataset Explorer** that lets analysts browse the full datasets, query an API, or download the underlying files directly. This is the route most compliance teams, journalists, and academic researchers use when they need to aggregate figures across an entire program year, since CMS does not publish a ready-made ranking of manufacturers by total dollar volume; any such ranking has to be built by querying the raw dataset directly or relying on a third-party analysis. Individual payment records are also fully browsable: for example, a Program Year 2025 record shows device maker **Alphatec Spine, Inc.** paying an orthopedic and neuro-spine surgeon a "**Royalty or License Payment amount \$119,970.00**" in a single January 2025 transaction (Source: openpaymentsdata.cms.gov), illustrating the level of transaction-level detail available to anyone willing to query individual records.

Data freshness matters for anyone building a search strategy, since CMS refreshes each program year's dataset the January after its initial June publication, meaning figures pulled at different points in the year can differ slightly as disputed records are corrected. The practical implication is that anyone citing an Open Payments total should record both the program year and the access date, since the underlying numbers are not frozen at first publication.

Pharmaceutical Companies Ranked by Reported Open Payments

Because CMS does not publish a pre-built company ranking, most "top payer" claims trace back either to CMS's own program-year summary bulletins, which break out totals by payment category and recipient type without naming individual companies (the full multi-year CMS trend appears in *Table 3* in the Data Analysis section below), or to independent analyses that query the raw dataset and name names directly.

Named companies come from independent analyses layered on top of the raw CMS files. STAT News, analyzing Program Year 2023 data, found that **AbbVie paid health care providers roughly \$145.7 million** in marketing-related payments, calling it **"the most a pharmaceutical company has spent on marketing"** since Open Payments records began (Source: www.statnews.com) (Source: www.statnews.com). A 2026 MedScout analysis of the newly released 2025 data, reported by Medscape, listed **BioNTech at \$536.4 million in reported payments**, more than twice the reported total for second-place AbbVie (Source: www.medscape.com). This is not a physician-only ranking: the reported BioNTech total included a payment to a teaching hospital. The analysis is careful to note the number is misleading if read as a marketing signal: BioNTech's total was inflated by a **"\$536 million royalty payment to the Hospital"** that was separately reclassified as **"not product-related"** (Source: www.medscape.com), tied to intellectual property connected to its Comirnaty COVID-19 vaccine rather than to physician marketing outreach. Across the full 2025 dataset, the same analysis found **royalties accounted for the largest share of payment dollars**, ahead of speaking and consulting fees (Source: www.medscape.com).

Company-level rankings have shifted considerably across the program's history. In 2015, the second full program year, MedCity News reported that **Novartis "shelled out the most to physicians in 2015 - a total of \$540 million"** (Source: medcitynews.com), a figure well above any single company's total General Payments a decade later. That early-era pullback in physician marketing was already visible before Open Payments even published its first data: an NPR analysis of the same underlying industry figures found that **Eli Lilly's speaker payments "dropped by 55 percent, from \$47.9 million in 2011 to \$21.6 million in 2012"**, and that **GlaxoSmithKline's "speaking tab plummeted from \$24 million in 2011 to \$9.3 million in 2012"** after the company stopped paying doctors for promotional talks altogether (Source: www.npr.org) (Source: www.npr.org). Not every company followed the same trajectory: the same report found **Johnson & Johnson "increased such spending by 17 percent from 2011 to 2012"** (Source: www.npr.org), underscoring that individual companies' responses to the coming transparency mandate varied widely even within the same window.

Academic research corroborates the broad multi-year pattern independently of any single company. A JAMA research letter examining the full 2013-2022 window found **85,087,744 payments with a total value of \$12.13 billion** made to physicians, with **57.1 percent of eligible physicians (826,313 of 1,445,944)** receiving at least one industry payment, and a **median payment of just \$48** (Source: pmc.ncbi.nlm.nih.gov) (Source: pmc.ncbi.nlm.nih.gov), underscoring that the large headline totals are driven by a relatively small number of large transactions layered on top of a much broader base of small, routine payments. The same analysis identified the specific drugs most closely tied to physician payments over the decade, led by the blood thinner **"Xarelto (\$176.34 million)"** (Source: pmc.ncbi.nlm.nih.gov). *Table 1* below places individual company examples against this backdrop.

Table 1 summarizes illustrative company-level figures drawn from independent analyses of the CMS data, spanning both pharmaceutical and device manufacturers and both routine marketing payments and one-off royalty or ownership transactions.

COMPANY	PERIOD	REPORTED AMOUNT	PAYMENT TYPE / CONTEXT	SOURCE
Novartis	2015 (second full program year)	\$540 million	General Payments, industry-wide leader that year	(Source: medcitynews.com)
AbbVie	Program Year 2023	approximately \$145.7 million	Marketing-related General Payments; record high at the time	(Source: statnews.com)
BioNTech	2025 data (published 2026)	\$536.4 million	Dominated by a single royalty payment later reclassified "not product-related"	(Source: medscape.com)
Zimmer Biomet	Recent program year	approximately \$134 million	General Payments, orthopedic device manufacturer	(Source: beckersspine.com)
Stryker Corporation	Program Year 2021	\$113,487,200.91	General Payments, orthopedic device manufacturer	(Source: cms.gov)
Insys Therapeutics	2014 (initial full year)	\$4,538,286	Opioid-related marketing payments tied to Subsys fentanyl spray	(Source: eurekalert.org)

The table illustrates a recurring theme in this data: a single large, legitimate royalty or acquisition-related transaction can distort a company's apparent ranking in ways that have nothing to do with routine physician marketing, which is why analysts increasingly report both a company's total Open Payments figure and the underlying nature-of-payment breakdown rather than a single headline number.

Medical Device and Medtech Companies: A Different Payment Profile

Device and diagnostics manufacturers show a payment profile that looks structurally different from pharmaceutical companies. CMS's own specialty ranking on the Open Payments homepage lists **"Orthopaedic Surgery Internal Medicine Neurology Dermatology Neurological Surgery"** in that order (Source: openpaymentsdata.cms.gov), meaning orthopedic surgery, a specialty defined by implantable hardware rather than prescription drugs, receives more disclosed industry payment value than any other specialty.

The driver is royalties and ownership interests rather than speaking fees. A peer-reviewed Cureus analysis of Open Payments records from 2014 through 2019 found that **"approximately \$1.6 billion) were made to orthopedic surgeons between 2014 and 2019"** across 28,475 individual surgeons (Source: pmc.ncbi.nlm.nih.gov), with sharp subspecialty concentration: **adult reconstruction surgeons averaged \$225,131** in total industry payments over the period and **spine surgeons averaged \$197,404** (Source: pmc.ncbi.nlm.nih.gov). A JAMA analysis of the broader 2013-2022 window is careful to note that its headline general-payment figures **"do not include payments made for acquisitions, loans, royalty or licensing fees"** (Source: jamanetwork.com), a methodological choice that likely understates the device sector's true footprint in any general-payments-only comparison, since royalty income is disproportionately concentrated among device-industry physician-inventors.

A single CMS record makes the mechanism concrete: the January 2025 Alphatec Spine royalty payment described in the previous section, made directly to an orthopedic and neuro-spine surgeon, is the kind of transaction that reflects a physician's role in designing or patenting an implant rather than promotional activity. KFF Health News' "Spinal Tap" investigation quantified the pattern at scale, finding **"more than \$3.1 billion flowed from device makers to surgeons from August 2013 through 2019"** (Source: kffhealthnews.org), and that surgeons **"had stakes in more than 200 privately owned device companies from 2013 through 2019,"** with those equity holdings topping \$300 million in value by the end of 2019 (Source: kffhealthnews.org). This is the concrete substance behind the Ownership and Investment Interest category described earlier, a payment type that applies only to physicians, not to non-physician practitioners or teaching hospitals.

Trade press coverage confirms the same royalty- and equity-driven pattern among the largest orthopedic device makers specifically. Becker's Spine Review found that the five largest orthopedic-focused device manufacturers, Zimmer Biomet, Arthrex, Stryker, DePuy Synthes, and Smith+Nephew, **"paid \$456.5 million to physicians"** combined in a single recent year (Source: www.beckersspine.com). A 2025 JBJS Open Access study examining \$4.5 billion in orthopedic surgeon payments from 2017 through 2023 found the distribution sharply skewed, with the **"top 1% of recipients receiving 77.4% of payment value"** (Source: doi.org), even though the **"most common payment category was food and beverage (66.3% of transactions)"** (Source: doi.org), meaning most individual transactions are trivial meals while a small number of physician-inventors and key opinion leaders capture the overwhelming majority of dollars.

The concentration extends beyond orthopedics into cardiology. A peer-reviewed abstract analyzing three years (2014-2016) of Open Payments data found **"\$520,167,233 were made to 30,372 cardiologists"** (Source: doi.org), with device makers **St. Jude Medical and Medtronic Vascular** as the two largest payers, and it found **"device manufactures such as Boston Scientific and Medtronic had a relatively higher proportion of spending on travel and ownership fees"** compared with pharmaceutical companies' more speaking- and consulting-weighted payment mix (Source: doi.org). Regulators have flagged the compliance risk this concentration creates: the HHS Office of Inspector General's 2013 Special Fraud Alert on physician-owned distributorships specifically addresses **"physician-owned entities that derive revenue from selling, or arranging for the sale"** of implantable devices ordered by their own physician-owners (Source: oig.hhs.gov), a structure that predates Open Payments but that the database now makes far easier to identify.

Payments by State and by Specialty

Because CMS discloses provider location alongside every transaction, Open Payments data can be aggregated geographically as well as by company or specialty. Unsurprisingly, the largest, most physician-dense states show the largest disclosed totals. For Program Year 2025, CMS's own state summary tool shows California physicians receiving general payments totaling **\$358,387,772.78** across **1,046,005** individual payments (Source: openpaymentsdata.cms.gov). New York trails meaningfully behind at **\$226,785,294.69** across **715,476** payments in the same program year (Source: openpaymentsdata.cms.gov). Nationally, CMS's state-summary view shows general payments to physicians totaling roughly **\$2,624,554,749.77** for 2025 (Source: openpaymentsdata.cms.gov), meaning California alone accounts for well over 10 percent of all general payments made to physicians nationwide that year.



Table 2 below places these state totals side by side with the national figure to illustrate the scale of concentration.

GEOGRAPHY	GENERAL PAYMENTS, PROGRAM YEAR 2025	NUMBER OF PAYMENTS
California	\$358,387,772.78	1,046,005
New York	\$226,785,294.69	715,476
United States (national, physicians)	\$2,624,554,749.77	approximately 10.1 million

California's general-payment total is roughly 58 percent higher than New York's, but that comparison alone cannot establish the role of specialty mix, physician headcount, or relative industry influence. California's 2025 population was about 97 percent higher than New York's, so population alone does not support the prior inference. Orthopedic surgery nonetheless ranks ahead of internal medicine, neurology, dermatology, and neurological surgery in total disclosed industry payments, and a JAMA research letter analyzing the full decade of Open Payments data from 2013 to 2022 found that **"orthopedic surgeons received the greatest sum of payments at \$1.36 billion"** of any specialty (Source: [pmc.ncbi.nlm.nih.gov](https://pubmed.ncbi.nlm.nih.gov/39111111/)). State or health-system comparisons require appropriate, stated denominators before drawing conclusions about relative industry influence.

Teaching Hospitals, Compliance Costs, and International Disclosure Regimes

Physicians are not the only covered recipients: teaching hospitals form a separate, financially significant category, and CMS's own Program Year 2022 bulletin counted **"588,514 physicians, 271,682 non-physician practitioner (NPPs), and 1,240 teaching hospitals"** sharing in that year's \$12.59 billion total (Source: [content.govdelivery.com](https://www.cms.gov/medicare/coverage/coverage-guides/2022/2022-coverage-guides-physician-and-non-physician-practitioner-payments)). The pattern dates to the program's first year: Modern Healthcare reported that in 2014, **"drug and medical-device companies paid teaching hospitals \$543 million in general payments"** (Source: [www.modernhealthcare.com](https://www.modernhealthcare.com/news/industry-payments-to-teaching-hospitals)), led by **City of Hope**, which alone **"received nearly \$250 million in royalties from Genentech"** tied to cancer-drug intellectual property (Source: [www.modernhealthcare.com](https://www.modernhealthcare.com/news/industry-payments-to-teaching-hospitals)), the same royalty-concentration dynamic seen among individual device-inventor physicians. A peer-reviewed analysis found that **91 percent of US teaching hospitals accept at least one industry payment annually** (Source: [pmc.ncbi.nlm.nih.gov](https://pubmed.ncbi.nlm.nih.gov/39111111/)), that teaching hospitals collectively took in more than **\$830 million** in industry payments in 2018 (Source: [pmc.ncbi.nlm.nih.gov](https://pubmed.ncbi.nlm.nih.gov/39111111/)), and that the great majority of

individual transactions to hospitals themselves were **"food and beverage" (98%) or "education" payments (34%)** rather than large research grants, even though dollar totals remain dominated by a comparatively small number of large royalty and research transactions (Source: [pmc.ncbi.nlm.nih.gov](https://pubmed.ncbi.nlm.nih.gov/)).

The program's compliance costs have been debated since before the first data even published. Trade coverage from the Sunshine Act's launch found that CMS's own initial estimate suggested the reporting mandate **"would likely cost the industry a total of \$269 million in the first year"** (Source: [isrreports.com](https://www.isrreports.com/)), an estimate industry commentary at the time viewed as conservative. A 2024 peer-reviewed difference-in-differences study later found a specific, measurable behavioral effect of the disclosure mandate itself: the Sunshine Act **"led to significant reductions in companies' meal-related payments, affecting both the total payment made"** to physicians, while separately noting an **"estimated annual industry compliance cost of \$180 million"** for the ongoing reporting requirement (Source: journals.plos.org) (Source: journals.plos.org), evidence that mandatory disclosure changes company behavior even without any change to the underlying legal prohibitions on kickbacks.

The United States remains comparatively unusual even among peer health systems in making disclosure both mandatory and centralized. The United Kingdom's system, run through the industry's own **ABPI Code of Practice**, is **"mandatory for all companies abiding by the ABPI Code of Practice"** and part of a wider movement the ABPI describes as spanning **"36 countries committed to open and ethical ways of working"** (Source: www.abpi.org.uk) (Source: www.abpi.org.uk), yet a peer-reviewed comparative review notes that, unlike the US system, **"in the United Kingdom, individual doctors can opt out from having their data released"** (Source: [pmc.ncbi.nlm.nih.gov](https://pubmed.ncbi.nlm.nih.gov/)), a material gap the US regime does not permit. France operates a government-run public database under its Public Health Code requiring health-sector companies to disclose agreements and remuneration, stating that companies **"doivent rendre publics les conventions, les rémunérations et les avantages accordés"** to health professionals (Source: www.data.gouv.fr). Japan takes a different, industry-led approach: its pharmaceutical association has run a voluntary guideline since 2011 under which company payments **"shall be disclosed through each company's own website"** rather than a centralized government database (Source: www.jpma.or.jp). The same comparative review found that **"in Australia, companies do not have to report the value of meals"** at all, a narrower disclosure scope than the US requires, and that Ontario, Canada, **"was on the verge of enacting an even more comprehensive piece of legislation"** than the US Sunshine Act before a change in government stalled it (Source: [pmc.ncbi.nlm.nih.gov](https://pubmed.ncbi.nlm.nih.gov/)) (Source: [pmc.ncbi.nlm.nih.gov](https://pubmed.ncbi.nlm.nih.gov/)). Despite more than a decade of transparency regimes across multiple countries, the same 2021 peer-reviewed review concluded that **"there is no evidence that physician behavior regarding COI has changed"** as a direct, demonstrated result of disclosure alone (Source: [pmc.ncbi.nlm.nih.gov](https://pubmed.ncbi.nlm.nih.gov/)), a sobering caveat against assuming transparency mechanically translates into changed clinical practice.

Data Analysis and Evidence

The clearest way to see the program's trajectory is a straight year-over-year comparison of CMS's own published totals. *Table 3* compiles the figures CMS has released across seven consecutive program years.

PROGRAM YEAR	TOTAL PAYMENTS AND OWNERSHIP/INVESTMENT INTERESTS	RECORDS PUBLISHED
2019	\$10.03 billion	10.98 million
2020	\$9.03 billion (COVID-era decline)	not separately reported in this source
2021	\$10.90 billion	12.10 million
2022	\$12.59 billion	14.11 million
2023	\$12.75 billion	15.64 million
2024	\$13.18 billion	16.16 million
2025	\$14.67 billion	17.07 million

Sources: Program Year 2019 from ASCO's summary of CMS's release (Source: www.asco.org); Program Year 2020 from an archived CMS Open Payments page (Source: web.archive.org); Program Year 2021 from CMS's news alert (Source: www.cms.gov); Program Year 2022 from CMS's program bulletin (Source: content.govdelivery.com); Program Year 2023 from CMS's program bulletin (Source: content.govdelivery.com); Program

Year 2024 from CMS's program bulletin (Source: content.govdelivery.com); and Program Year 2025 from CMS's dataset landing page (Source: openpaymentsdata.cms.gov).

The table shows a consistent upward trend since the pandemic-era trough, with total disclosed value rising roughly 35 percent from Program Year 2021's \$10.90 billion to Program Year 2025's \$14.67 billion, while records grew roughly 41 percent from 12.10 million to 17.07 million. On these published totals, the average value per record decreased modestly, from about \$901 in 2021 to about \$859 in 2025. CMS's cumulative counters corroborate the trend: from **"80.66 million records amounting to \$68.44 billion"** published cumulatively through Program Year 2022 (Source: content.govdelivery.com) to **"93.87 million records, accounting for \$82.24 billion"** cumulatively through the current active reporting window (Source: www.cms.gov). Recipient counts have grown alongside dollar totals: Program Year 2024's \$13.18 billion was attributed to **"651,977 physicians, 338,340 non-physician practitioners"** and 1,288 teaching hospitals, up more than 24 percent in non-physician practitioner counts from two years earlier (Source: content.govdelivery.com).

Independent, longer-run research adds texture that CMS's own year-by-year bulletins do not directly provide. A STAT News analysis of a JAMA study found the share of physicians accepting **"at least one industry payment"** fell from **52.2 percent in 2014 to 45 percent in 2018** (Source: www.statnews.com), even as **"doctors received 49.8 million payments overall totaling \$9.3 billion"** across that same 2014-2018 window (Source: www.statnews.com), a combination suggesting payments have become concentrated among a smaller pool of recipients even as fewer physicians participate overall. More recent trade coverage of the June 2026 data release cited a 2026 study presented at the American Society of Clinical Oncology's annual meeting finding that **"oncologists were more likely to prescribe a treatment if they received a related general payment"** (Source: www.healthcare-brew.com), extending the same payment-and-prescribing association documented in the Hadland opioid study, discussed below, to a very different therapeutic area roughly a decade later.

Whether disclosure changes patient or physician behavior is a separate, more contested question than whether the data itself is accurate. A national survey found that just **12 percent of respondents knew that payment information was publicly available** at all (Source: pubmed.ncbi.nlm.nih.gov), even though **65 percent had seen a physician who had received an industry payment during the previous 12 months** (Source: pubmed.ncbi.nlm.nih.gov). Among the minority of patients who do engage with the data, a randomized study published in the Journal of General Internal Medicine found that **"physicians who received payments over \$13,000 received lower ratings for honesty"** from patients shown the disclosure (Source: link.springer.com), suggesting disclosure can shift perception meaningfully once patients actually see it, even though general public awareness of the tool remains low.

Case Studies and Real-World Examples

The Hadland Study: Linking Opioid Marketing Payments to Prescribing Behavior

A 2018 JAMA Internal Medicine study led by Dr. Scott Hadland of Boston Medical Center's Grayken Center for Addiction used CMS Open Payments and Medicare Part D prescribing data together, examining the **"Association of Pharmaceutical Industry Marketing of Opioid Products to Physicians With Subsequent Opioid Prescribing"** (Source: jamanetwork.com). The study identified **369,139 physicians** who prescribed opioids under Medicare Part D in 2015, of whom **25,767, or 7 percent, had received opioid-related industry payments in 2014** (Source: www.eurekalert.org). The study found that **"receipt of any opioid marketing in 2014 was associated with 9.3 percent more opioid claims in 2015"** among physicians who received payments compared with those who did not (Source: www.eurekalert.org). The three companies with the highest opioid-related payment totals in the study's 2014 data were **"INSYS Therapeutics (\$4,538,286), Teva Pharmaceuticals USA (\$869,155) and Janssen Pharmaceuticals (\$854,251)"** (Source: www.eurekalert.org). Hadland drew a direct policy conclusion from the finding, noting that **"the impact on prescribing habits is quite large when considered across the entire workforce"** (Source: www.eurekalert.org), one of the earliest and most-cited demonstrations that Open Payments data could be used to detect a measurable link between industry payments and clinical behavior during the height of the U.S. opioid crisis.

ProPublica's "Dollars for Docs": Insys Therapeutics and the Subsys Bribery Scheme

In 2019, ProPublica's "Dollars for Docs" investigative project analyzed **more than 56 million Open Payments records from 2014 to 2018** and found that **more than 2,500 physicians received at least \$500,000 each** from drug and device companies over that span, and **"more than 700 of those doctors received at least \$1 million"** (Source: www.propublica.org) (Source: www.propublica.org). The investigation singled out opioid manufacturer **Insys Therapeutics**, documenting that the company **"spent \$7.5 million promoting Subsys"**, its fentanyl spray, in 2014 alone, with that figure climbing to \$17.6 million by 2018 (Source: www.propublica.org). The Department of Justice later found that the company's ostensibly educational

programs **"were actually used as a vehicle to pay bribes and kickbacks to targeted practitioners"** to boost Subsys prescriptions and dosages (Source: www.propublica.org). Insys ultimately pleaded guilty to five counts of mail fraud, agreeing to **"pay a \$2 million fine and forfeit \$28 million"** (Source: www.propublica.org), and separately paid \$195 million to settle a related whistleblower case, with at least eight company executives ultimately convicted.

Biogen's \$900 Million False Claims Act Settlement Over Speaker Programs

In September 2022, the Department of Justice announced that **Biogen Inc.** had agreed **"to pay \$900 million to resolve allegations that it caused the submission of false claims"** tied to a multi-year kickback scheme (Source: www.justice.gov). The whistleblower lawsuit alleged that between January 2009 and March 2014, Biogen paid speaker honoraria, training fees, consulting fees, and meals **"to induce them to prescribe the drugs Avonex, Tysabri and Tecfidera, in violation of the Anti-Kickback Statute"** (Source: www.justice.gov). Under the settlement, **Biogen paid \$843,805,187 to the federal government and \$56,194,813 to 15 states** (Source: www.justice.gov), with the whistleblower receiving roughly 29.6 percent of the federal recovery, illustrating how litigation drawing on the same categories, speaker honoraria and consulting fees, that Open Payments now discloses publicly can still take years to unwind through the courts.

Continued Federal and State Enforcement: Pfizer/Biohaven, Gilead, and Texas v. Sanofi (2025-2026)

In January 2025, the Department of Justice announced that **Pfizer**, acting on behalf of its acquired subsidiary **Biohaven**, had agreed **"to pay \$59,746,277 to resolve allegations that, prior to Pfizer's acquisition"**, Biohaven had run an improper speaker bureau for its migraine drug Nurtec ODT (Source: www.justice.gov). Reuters' coverage of the same settlement quoted the government's allegation that Biohaven's program involved **"providing speaker honoraria and meals at high-end restaurants to doctors"** (Source: www.reuters.com) from March 2020 through September 2022, practices that ended once Pfizer completed its acquisition of Biohaven.

Three months later, in April 2025, Reuters reported that **Gilead Sciences** agreed to pay **\$202 million** to settle a separate whistleblower suit alleging the company was **"paying kickbacks to doctors who agreed to prescribe its HIV drugs"** (Source: www.reuters.com). And in February 2026, Reuters reported that Texas Attorney General Ken Paxton sued **Sanofi**, alleging the company **"created programs to offer services to healthcare providers, which it alleges amounted to bribes"** designed to boost prescriptions (Source: www.reuters.com), a state-level action rather than a federal DOJ settlement that signals state attorneys general are now pursuing the same category of physician-payment evidence that Open Payments discloses at the federal level. Together, these three actions across roughly fourteen months show that speaker-program and provider-services scrutiny has not slowed since the Insys and Biogen cases, and that enforcement now comes from both federal and state authorities simultaneously.

KFF Health News' "Spinal Tap": Orthopedic Surgeon Ownership in Device Companies

KFF Health News' investigative series "Spinal Tap" used Open Payments Ownership and Investment Interest data to document how orthopedic and spine surgeons have built direct equity stakes in the device companies whose products they implant. The investigation found that **"surgeons had stakes in more than 200 privately owned device companies from 2013 through 2019"** (Source: kffhealthnews.org), with those stakes topping \$300 million in value by 2019, and it named specific physicians and dollar figures: orthopedic surgeon **John Steinmann received \$16.4 million in "ownership and investment interest" from Renovis Surgical Technologies in 2019 alone** (Source: kffhealthnews.org). The investigation also found that when **Medtronic acquired spinal-implant maker Titan Spine in June 2019, "two dozen physician investors received more than \$17 million in payments"** as part of the transaction (Source: kffhealthnews.org), showing that acquisition events, not just annual royalty streams, can generate large, one-time Ownership and Investment Interest disclosures.

Implications and Future Directions

The volume and structure of Open Payments data have grown to the point where manual review is no longer a realistic compliance strategy for either regulators or the manufacturers themselves. CMS's own program contractor, Econometrica Inc., lists **"Artificial Intelligence/Machine Learning, Data Visualization, Healthcare Industry Data Analysis"** among its listed work areas on the Open Payments program itself (Source: econometricainc.com), a direct acknowledgment that the scale of the dataset, now approaching 94 million cumulative records, benefits from automated analysis rather than manual audit. Independent developers have applied similar techniques to the public data: one open-source project

describes **"rule-based + ML anomaly detection across 16M+ CMS Open Payments records"** (Source: github.com), illustrating that the tooling needed to flag high-risk physician-industry financial relationships at scale is increasingly accessible outside government and large manufacturers alike.

Parallel to CMS's mandatory disclosure regime, industry trade associations maintain their own voluntary codes of conduct that predate and layer on top of the federal reporting requirement. **PhRMA's** Code on Interactions with Health Care Professionals caps permissible educational items at those **"not of substantial value (\$100 or less)"** (Source: cdn.agility.io) and explicitly states that member companies **"should not provide any entertainment or recreational items, such as tickets to the theater"** (Source: cdn.agility.io). **AdvaMed's** parallel Code of Ethics for the device industry frames its own physician-interaction guidance around a defined set of **"cornerstone values"** (Source: www.advamed.org). Health systems have layered their own internal governance on top of both: Cleveland Clinic's conflict-of-interest policy requires internal committee review whenever a clinician's financial interest in a company whose products they use or prescribe **"requires review of financial interests greater than \$20,000 in a year"** (Source: www.researchgate.net), a threshold hundreds of times larger than the roughly \$48 median individual Open Payments transaction, underscoring that federal disclosure, industry self-regulation, and institutional oversight now operate as three distinct, complementary layers rather than a single mechanism.

For pharmaceutical and device manufacturers, the compliance calculus has shifted from "avoid reporting errors" toward "actively manage the reputational and regulatory signal the data sends." Given the civil monetary penalty exposure detailed earlier and the fact that journalists, state attorneys general, and academic researchers now routinely mine the same public dataset for stories, lawsuits, and studies, commercial and medical-affairs teams increasingly want visibility into their own reportable exposure before the annual June publication, not after. This is the specific gap that analytics tools built for the life-sciences sector, such as **IntuitionLabs'** KOL segmentation and compliance-oriented analytics offerings, are designed to address: identifying which physicians a company's field or medical affairs teams engage most heavily, and flagging documentation gaps, ahead of the annual disclosure cycle rather than reacting to it after the fact (Source: intuitionlabs.ai). The regulatory scope of the program itself also continues to evolve: the 2021 expansion to non-physician practitioners has already added hundreds of thousands of covered recipients, and steady year-over-year growth in that population suggests the program's overall footprint will keep expanding even if per-physician payment behavior stays flat.

Frequently Asked Questions (FAQs)

What is the Open Payments database? Open Payments is the CMS-administered federal database, created under Section 6002 of the Affordable Care Act, that discloses payments and transfers of value from drug and device manufacturers to physicians, non-physician practitioners, and teaching hospitals, as described in the Introduction above.

How does one search the CMS Open Payments database? Use the free Open Payments Search Tool at openpaymentsdata.cms.gov, which lets users search by individual provider, teaching hospital, or company name, and filter by state, city, ZIP code, provider type, and specialty (Source: openpaymentsdata.cms.gov); more technical users can query the Dataset Explorer via API or bulk download.

What is the difference between General Payments and Research Payments? General Payments cover consulting fees, speaking fees, meals, travel, royalties, and similar transfers not tied to a study, while Research Payments are tied to a formal research agreement or protocol and can be attributed to an institution rather than an individual physician, as detailed earlier in this report. For Program Year 2025, Research Payments totaled **"\$9.50 Billion Research Payments"**, more than double the \$3.92 billion in General Payments that year (Source: www.cms.gov).

Which company pays doctors the most? CMS does not publish an official company ranking, so there is no official answer. A third-party MedScout analysis reported by Medscape—not a CMS-published aggregation—identified BioNTech's \$536.4 million as the largest single-company total in the 2025 data; the reported figure was driven by one large royalty payment rather than routine marketing (Source: www.medscape.com). In Program Year 2023 data, AbbVie led in marketing-related payments at roughly \$145.7 million (Source: www.statnews.com); in 2015, the program's second full year, Novartis topped the list at \$540 million (Source: medcitynews.com).

How does medtech industry payment data differ from pharma? Device manufacturers show far higher concentrations of royalty and ownership/investment payments, particularly in orthopedic surgery and cardiology, reflecting physician-inventor relationships and equity stakes in device startups rather than promotional speaking arrangements (Source: pmc.ncbi.nlm.nih.gov) (Source: kffhealthnews.org).

When is Open Payments data updated? CMS publishes full datasets for the prior program year on or before June 30 each year, and refreshes the data again in January (Source: www.cms.gov); the next scheduled refresh is January 2027 (Source: openpaymentsdata.cms.gov).

What happens if a company fails to report payments accurately? Manufacturers and group purchasing organizations face civil monetary penalties ranging from \$1,000 to \$10,000 per unreported payment for unknowing violations, and \$10,000 to \$100,000 per payment for knowing violations, capped at \$1,000,000 annually per entity (Source: www.ecfr.gov).

Does the United States have the only mandatory physician-payment disclosure regime? No. The UK operates Disclosure UK under the industry-run ABPI Code, though individual doctors there can opt out of publication (Source: pmc.ncbi.nlm.nih.gov); France runs a government-operated database under its Public Health Code (Source: www.data.gouv.fr); and Japan relies on a voluntary, company-by-company disclosure guideline rather than a centralized database (Source: www.jpma.or.jp).

Conclusion

Open Payments has evolved from a five-month pilot disclosure covering \$3.5 billion in 2014 into a mature, mandatory federal transparency regime that, as of the June 2026 Program Year 2025 publication, discloses \$14.67 billion across 17.07 million individual records annually. The program's three-category structure, General Payments, Research Payments, and Ownership and Investment Interests, matters more than any single headline total: Research Payments now make up the largest share of disclosed dollars, pharmaceutical marketing spend is concentrated among a handful of large payers whose rankings can shift dramatically based on one-off royalty transactions, and medical device manufacturers show a structurally different profile driven by physician-inventor royalties and equity stakes concentrated in orthopedic surgery and cardiology. State and specialty data confirm that raw dollar totals are driven as much by specialty mix as by physician headcount, teaching hospitals form a separate, financially significant recipient category in their own right, and the United States remains internationally distinctive for making disclosure both mandatory and centralized, in contrast to opt-out regimes in the UK, voluntary self-disclosure in Japan, and narrower reporting scopes in Australia. Peer-reviewed research examines associations between industry payments and prescribing, while the enforcement actions discussed in this report demonstrate continued scrutiny of alleged improper financial relationships. Those settlements and allegations do not by themselves establish that Open Payments data detected or enabled the individual investigations or prosecutions. For manufacturers, compliance teams, researchers, and journalists alike, the database's growing scale increasingly rewards those equipped with systematic, automated approaches to querying and monitoring it, ahead of each year's publication cycle rather than in response to it.

Tags: open payments 2026, pharma payments to physicians, sunshine act, cms open payments database, physician payments sunshine act, medtech physician payments, open payments by company, pharma physician payment transparency

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