UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

IN RE: INSULIN PRICING LITIGATION

THOMAS JEFFERSON UNIVERSITY AND JEFFERSON HEALTH CORPORATION,

Plaintiffs,

v.

ELI LILLY AND COMPANY; NOVO NORDISK INC.; SANOFI-AVENTIS U.S. LLC; EVERNORTH HEALTH, INC. (FORMERLY EXPRESS SCRIPTS HOLDING COMPANY); EXPRESS SCRIPTS, INC.; EXPRESS SCRIPTS ADMINISTRATORS, LLC; MEDCO HEALTH SOLUTIONS, INC.; ESI MAIL PHARMACY SERVICE, INC.; EXPRESS SCRIPTS PHARMACY, INC.; ASCENT HEALTH SERVICES, LLC; CVS HEALTH CORPORATION; CVS PHARMACY, INC; CAREMARK RX, LLC; CAREMARK PCS HEALTH, LLC; CAREMARK, LLC; ZINC HEALTH SERVICES, LLC; UNITEDHEALTH GROUP, INC.;; OPTUM, INC.; OPTUMRX INC.; OPTUMINSIGHT, INC.; and EMISAR PHARMA SERVICES LLC

Defendants.

CASE NO. 2:23-md-03080 (BRM)(LDW)
MDL No. 3080

JUDGE BRIAN R. MARTINOTTI

JUDGE LEDA D. WETTRE

Case No.: 25-cv-19048

COMPLAINT

JURY TRIAL DEMANDED

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Pursuant to the Court's Amended Case Management Order No. 9, Plaintiffs, the Thomas Jefferson University and Jefferson Health Corporation (together, "Plaintiffs" or "Jefferson Health"), files this Complaint directly in this multi-district litigation ("MDL") proceeding. Absent the Order, Plaintiffs would have filed its case in the United States District Court for the Eastern District of Pennsylvania, the "Designated Forum."

I. INTRODUCTION

1. Over the past two decades, diabetes medication prices have jumped astronomically, far beyond inflation, with the cost of some diabetes medications escalating more than tenfold while the average cost of consumer goods and services rose only 1.75-fold.

2. This disparity is not attributable to any extrinsic market pressures, such as growing costs of production, materials, investment, or research and development. Instead, it is the result of concerted efforts by Defendants, who consist of drug manufacturers and pharmacy benefit managers (defined in further detail below), to unscrupulously manipulate prices and increase their profit margins at the expense of their healthcare payor counterparts like Plaintiffs.

3. The United States' market for diabetes treatment is enormous and only expanding, with one in four healthcare dollars spent on such care. According to the American Diabetes Association, the total estimated cost of diabetes in the United

States has climbed from $327 billion in 2017 to over $412 billion in 2022, with direct costs escalating from $227 billion in 2012 to $306.6 billion in 2022—an increase of approximately $80 billion.

4. About 10% of the adult population, or over 1.1 million adults, suffer from diabetes in Pennsylvania.[1] Their treatment costs about $12.3 billion annually in direct medical expenses.[2]

5. The Defendant manufacturers named herein, Defendants Eli Lilly, Novo Nordisk, and Sanofi (collectively, the "Manufacturer Defendants" or the "Manufacturers"), produce nearly all insulins and other diabetes medications available in the United States. In 2020—as in years past—these three Manufacturer Defendants controlled 92% (by volume) and 96% (by revenue) of the global market for diabetes drugs.

6. The Defendant pharmacy benefit managers named herein, Defendants CVS Caremark, Express Scripts, and OptumRx (collectively, the "PBM Defendants" or the "PBMs") consist of (a) the three largest pharmacy benefit managers in the United States (controlling more than 80% of the market) and (b) the largest pharmacies in the United States (comprising three of the top five dispensing

[1] *See* American Diabetes Association, *The Burden of Diabetes in Pennsylvania* (May 2025), https://diabetes.org/sites/default/files/2025-05/the-burden-of-diabetes-pennsylvania-05-08-25.pdf (last visited Dec. 11, 2025).

[2] *Id.*

pharmacies in the U.S.), and are (c) subsidiaries owned and controlled by parent entities that own three of the largest insurers in the United States—Aetna (CVS Caremark), Cigna (Express Scripts), and UnitedHealthcare (OptumRx). To illustrate:

PBM	PBM-Affiliated Insurer	PBM-Affiliated Pharmacy
CVS Caremark	Aetna	CVS Pharmacy
Express Scripts	Cigna	Express Scripts Pharmacy Inc.
Optum	UnitedHealthcare	OptumRx

7. Pharmaceutical benefit managers are at the center of the complex pharmaceutical distribution chain that delivers medicines from manufacturers to patients. They serve as middlemen, negotiating the terms and conditions for access to prescription drugs for hundreds of millions of Americans.[3]

8. As applicable here, the PBMs establish national formulary offerings (i.e., approved-drug lists) that determine which diabetes medications are covered by nearly every payor in the United States, including Plaintiffs.

9. In theory, PBMs' control over national formulary offerings gives them the market power to negotiate lower drug prices, including diabetes medications sold by the Manufacturer Defendants, which is the reason payors like Plaintiffs contract

[3] *See* The Federal Trade Commission, Interim Staff Report (July 2024), Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies, https://www.ftc.gov/reports/pharmacy-benefit-managers-report , at p. 1 (last visited Dec. 11, 2025).

with them.

10. In practice, the PBMs have conspired, and continue to conspire, with the Manufacturers to raise the cost of diabetes medications, thereby benefiting them at the payors' expense.

11. Little about these medications has changed over the past one hundred years; today's $350 insulin is essentially the same product the Manufacturers sold for $20 in the 1990s.

12. The tragic irony of Defendants' scheme, and its impact on prices, is that it betrays the intent of insulin's inventors, who sold their original patent rights to the University of Toronto for $1 each, reasoning that "[w]hen the details of the method of preparation are published anyone would be free to prepare the extract, but no one could secure a profitable monopoly."[4] One of the inventors, Sir Frederick Banting, stated that "[i]nsulin does not belong to me, it belongs to the world."[5] But today, in contrast to its inventors' noble aims, insulin is the poster child for skyrocketing pharmaceutical prices.

[4] The "Miracle" Discovery that Reversed the Diabetes Death Sentence, Noble Prize (Nov. 13, 2024), https://www.nobelprize.org/the-miracle-discovery-that-reversed-the-diabetes-death-sentence/ (last visited Dec. 11, 2025)

[5] *Id.*

The Circumstances Leading to Defendants' Insulin Pricing Scheme And Its Effects On Insulin Prices

13. Contrary to the purpose for which payors like Plaintiffs contract with them, the PBM Defendants collaborate with the Manufacturers to control the availability and price of the Manufacturers' diabetes medications throughout most of the U.S. market.[6]

14. The Manufacturers and PBMs appreciate the PBMs' market power and the crucial role their standard formularies play in the pharmaceutical payment chain, as well as the PBMs' enormous influence over drug prices and purchasing behavior.

15. The Manufacturers and PBMs understand that the PBMs' national formularies drive drug utilization. The more accessible a drug is on the PBMs' national formularies, the more that drug will be purchased throughout the United States. Conversely, the exclusion of a drug from one or more of the PBMs' formularies can render the drug virtually inaccessible for millions of covered persons.

16. At the same time, the PBMs effectively set drug prices as they ostensibly "negotiate" such prices with the Manufacturers on behalf of payors.

17. For transactions in which the PBM Defendants control the insurer, the PBM, and the pharmacy (e.g., CVS Caremark–Aetna–CVS Pharmacy)—these middlemen capture as much as half of the money spent on each insulin prescription

[6] The diabetes medications at issue are set forth in the table in paragraph 270.

up from 25% in 2014. They characterize these amounts as "administrative" expenses or other innocuous-sounding labels (as detailed below), even though these charges are essentially economic "rent," contributing nothing to the distribution, improvement, development or manufacture of the drugs.

18. Under these circumstances, the Manufacturers and PBMs have unchecked incentives to raise insulin drug prices: it increases the Manufacturers' overall revenue and profits generally, while the PBMs receive a share of that growing revenue, thereby boosting their own profits also. At the same time, the increased costs are simply passed on to payors like Plaintiffs, so there is no detriment to either the Manufacturers or the PBMs.

19. The unfair and deceptive conspiracy at the heart of this Complaint—the "Insulin Pricing Scheme"—arose from this mutual understanding. The rising list prices of insulin over the years reflect the effects of Defendants' scheme due to that mutual understanding.

20. Insulin medication, which cost Manufacturers as little as $2 per vial to produce and was once sold for $20 per vial in the 1990s, now ranges from $300 to over $700.

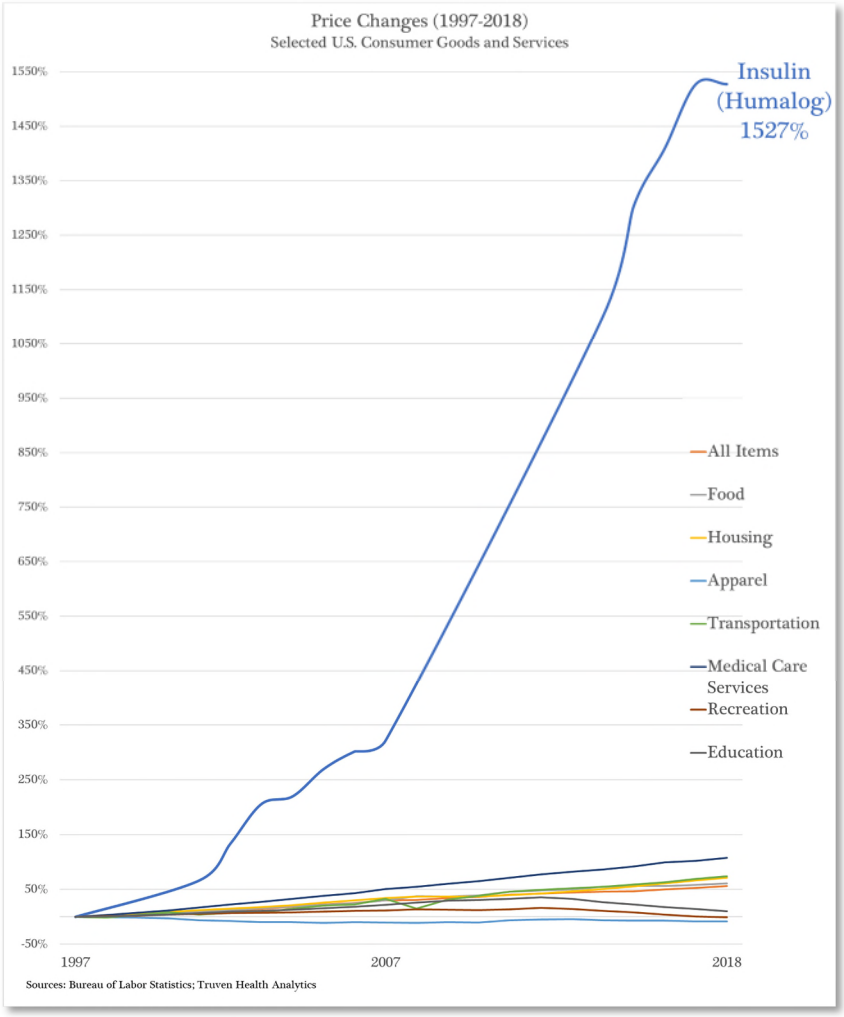
21. Rather than compete on price as would occur in a healthy market, the Manufacturer Defendants have instead increased their insulin prices in tandem up to 1000%. Indeed, the Manufacturers made the same price increases down to the

decimal point within a few days of one another and, according to a U.S. Senate Finance Committee investigation, "sometimes mirroring" one another in "days or even hours."[7]

22. To illustrate, the Manufacturer Eli Lilly raised the list price of its analog insulin, Humalog, at rates far exceeding the rate of inflation for other consumer goods and services between 1997 and 2018.

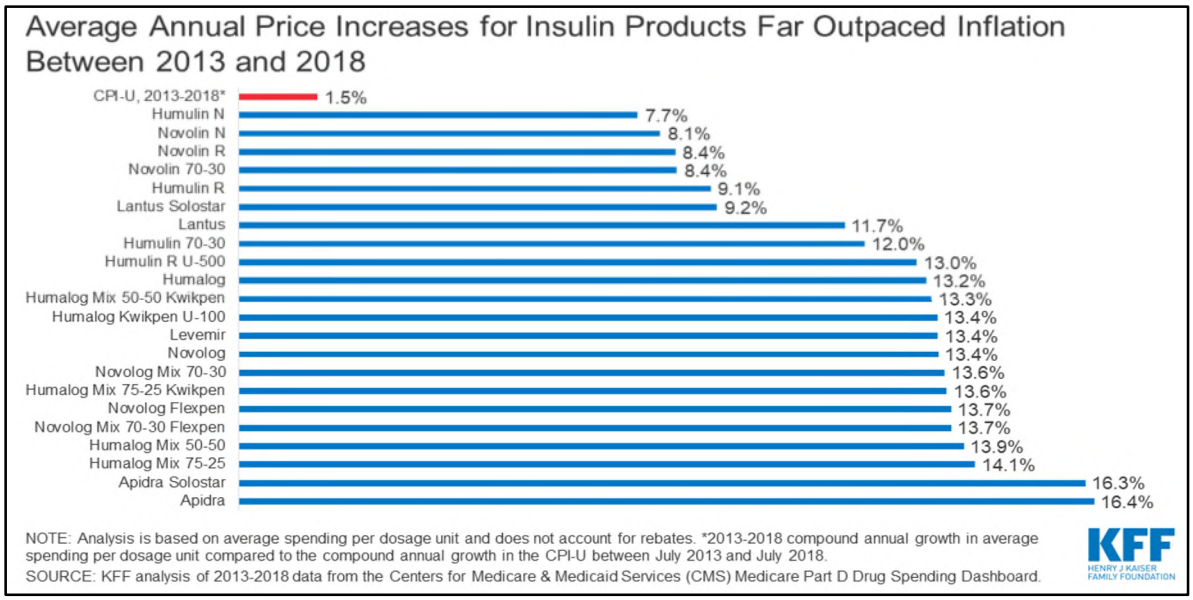
[7] Charles E. Grassley & Ron Wyden, *Staff Report on Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug*, *Sen. Fin. Comm.*, at 6, 54, 55 (Jan. 2021),https://www.finance.senate.gov/imo/media/doc/Insulin%20Committee%20Print.pdf(hereinafter "Senate Insulin Report") (last visited Dec. 11, 2025).

Figure 1: Price Increase of Insulin (Humalog) vs. Selected Consumer Goods, 1997-2018



23. And as reflected in the chart below from the Kaiser Family Foundation, insulin prices have increased at rates far exceeding inflation between 2013 and 2018.

Figure 2: Average annual price increases of insulins vs. inflation, 2013-2018



How the Insulin Pricing Scheme Works

24. Generally, there are four categories of participants in the diabetes medication chain.

- *Health Insurance Plans.* Health insurance plans, often funded by employers such as Plaintiffs, provide coverage and reimbursements for individuals' medical treatment and care. These plans often include pharmacy benefits, meaning that the health plan pays a substantial share of the purchase price of its beneficiaries' prescription drugs, which includes the diabetes medications at issue. Operators of these plans may be referred to as payors or plan sponsors (or PBM "clients"). The three main types of payors are government/public payors, commercial payors,

and private payors.

- *Pharmacy Benefit Managers.* As indicated above, payors routinely engage pharmacy benefit managers to manage their prescription benefits, which includes negotiating prices with drug manufacturers and (ostensibly) helping payors manage drug spending. Each pharmacy benefit manager maintains a formulary—a list of covered medications. A pharmacy benefit manager's power to include or exclude a drug from its formulary should theoretically incentivize manufacturers to lower their list prices. Pharmacy benefit managers also contract with pharmacies to dispense medications purchased by the plan's beneficiaries. Pharmacy benefit managers are compensated by retaining a portion of what—again in theory—should be shared savings on the cost of medications.
- *Rebate Aggregators.* Rebate aggregators are group purchasing organizations (GPO) that negotiate and collect rebates and other fees for pharmacy benefit manager clients. Each of the three PBM Defendants here established their own rebate aggregator GPO (Defendants Zinc, Ascent, and Emisar) between 2018 and 2022, to outsource the negotiation and collection of rebates and other fees to a subsidiary, and impose new fees on the Manufacturers, purportedly for the aggregator's services. The PBM Defendants' rebate aggregators allow the PBMs to further obfuscate

the rebate payment trail and extract additional profits from their contracts with payors.

- *Manufacturers*. As indicated above, Manufacturers produce the insulin medications at issue.[8] Each Manufacturer sets a list price for its products. The term "list price" often is used interchangeably with "Wholesale Acquisition Cost" or "WAC." The manufacturers self-report their list prices to publishing compendia such as First DataBank, Medi-Span, or Redbook, who then publish those prices.[9]

25. In theory, the PBMs' purchasing power and control over formularies dictating the availability of insulin drugs should have driven down drug list prices for payors since drug manufacturers normally compete for inclusion on the standard national formularies by lowering prices.

[8] There are three types of insulin medications. First are *biologics*, which are manufactured insulins derived from living organisms. Second are *biosimilars*, which are "highly similar" copies of biologics. They are similar in concept to "generic" drugs; but in seeking approval, biosimilars use biologics (rather than drugs) as comparators. Third, the confusingly-named *authorized generics* are not true generics—they are approved brand-name drugs marketed without the brand name on the label. The FDA originally approved insulins as drug products rather than biologics. As a result, although a regulatory pathway existed to introduce biosimilars generally (i.e., copies of biologics), companies could not introduce insulin biosimilars because their comparators were "drugs" rather than "biologics." In 2020, the FDA transitioned insulin to the biologic regulatory pathway, thereby enabling the approval of biosimilars through an abbreviated approval process.

[9] The related "Average Wholesale Price" (AWP) is the published price for a drug sold by wholesalers to retailers.

26. In practice, however, the Manufacturers gain the PBMs' approval and access to their formularies by artificially *inflating* their list prices and then paying a significant, yet undisclosed, portion of that inflated price back to the PBMs (collectively, the "Manufacturer Payments").[10] The Manufacturer Payments bear a variety of dubious labels, including rebates, discounts, credits, inflation/price protection fees, and administrative fees. By whatever name, the inflated list prices and resulting Manufacturer Payments are a quid pro quo for inclusion and favorable placement on the PBMs' formularies.[11]

27. Contracts between the PBMs and payors like Plaintiffs, directly and/or through its agent, tie the definition of "rebates" to patient drug utilization. But the contracts between the PBMs and Manufacturers define "rebates" and other Manufacturer Payments differently, e.g., by calling rebates for formulary placement

[10] In this complaint, "Manufacturer Payments" is defined to include all payments or financial benefits of any kind conferred by the Manufacturer Defendants to the PBM Defendants (or a subsidiary, affiliated entity, or group purchasing organization or rebate aggregator acting on a PBM Defendant's behalf), either directly via contract or indirectly via Manufacturer-controlled intermediaries. Manufacturer Payments includes rebates, administrative fees, inflation fees, pharmacy supplemental discounts, volume discounts, price or margin guarantees and any other form of consideration exchanged.

[11] Favorable or preferred placement may, for example, involve placing a branded product in a lower cost-sharing tier or relaxing utilization controls (such as prior authorization requirements or quantity limits). Favorable placement of a relatively more expensive drug encourages use of that drug and leads to higher out-of-pocket costs for payors and co-payors.

"administrative fees." Defendants consequently profit from the "rebates" and other Manufacturer Payments, which are shielded from payors' contractual audit rights, thereby precluding payors from verifying the components or accuracy of the "rebates" that payors receive.

28. In recent years, the PBM Defendants have further masked the rebate payment trail by forming group purchasing organizations ("GPOs") known as "rebate aggregators." These PBM subsidiaries—as relevant here, Defendants Zinc (CVS), Ascent (Express Scripts), and Emisar (OptumRx)—negotiate rebates and other fees on the PBMs' behalf and retain a portion of the rebates and fees collected. As a result, these fees are neither passed through to payors nor subject to audit under the terms of payors' sponsor agreements with the PBMs. Because the rebate aggregators are PBM subsidiaries, however, the PBMs secure additional profits from each drug purchase.

29. The PBM Defendants' staggering revenues vastly exceed the fair market value of their services—which is negligible, if not negative, as they actually *drive up* drug costs—both generally and with respect to the diabetes drugs at issue.

30. The Manufacturers' initial list prices for the diabetes drugs at issue are not the result of free market competition for payors' business. To the contrary, their list prices are so exorbitant relative to the net prices they ultimately realize that the Manufacturers know their initial list prices are effectively false. These list prices

reflect neither the Manufacturers' actual costs to produce the at-issue drugs nor the fair market value of those drugs. Rather, they are artificially inflated solely to facilitate the Insulin Pricing Scheme.[12]

31. The PBM Defendants grant formulary status based on (a) the *highest inflated price*—which the PBMs know to be false—and (b) which diabetes medications generate the largest profits for themselves.

32. The Insulin Pricing Scheme thus creates a "best of both worlds" scenario for Defendants. The Manufacturers increase their sales and revenues by being favorably placed on formularies, while the PBMs receive a portion of the Manufacturer's sales though lucrative and secret Manufacturer Payments based on the Manufacturers' list prices. As the PBMs receive increasing Manufacturer Payments, the Manufacturers simply raise their list prices further.

33. The PBM Defendants profit off the Insulin Pricing Scheme in many ways, including: (a) retaining a significant, yet secret, share of the Manufacturer Payments, either directly or through rebate aggregators like Defendants Zinc, Ascent, and Emisar, (b) using the prices produced by the Insulin Pricing Scheme to generate

[12] "Net price" refers to the price the manufacturer ultimately realizes—that is, the list price less rebates, and other discounts (net sales divided by volume). At times, Defendants' representatives use "net price" to refer to the amount payors or plan members pay for medications. In this Complaint, "net price" refers to the former—the amount that the Manufacturers realize for the at-issue drugs, which is roughly the list price less Manufacturer Payments.

unwarranted profits from pharmacies, and (c) relying on those same artificial list prices to drive up the PBMs' margins and pharmacy-related fees, including those relating to their mail-order pharmacies. In addition, because the PBM Defendants claim that they can extract higher rebates due to their market power, ever-rising list prices increase demand for the PBMs' purported negotiation services.

34. As detailed below, although the PBM Defendants represent both publicly and directly to consumers, their client payors and payor agents that they use their market power to drive down prices for diabetes medications, these representations are false and deceptive. Instead, the PBMs intentionally incentivize the Manufacturers to inflate their list prices. The PBMs' "negotiations" intentionally drive up the price of the at-issue drugs and are directly responsible for the skyrocketing prices of diabetes medications, conferring unearned benefits upon the PBMs and Manufacturers alike.

35. Because the purchase price of every at-issue diabetes medication flows from a false list price generated by Defendants' unfair and deceptive scheme, every payor in the United States that purchases these life-sustaining drugs, including Plaintiffs, directly and/or through its agents, has been directly harmed by the Insulin Pricing Scheme.

36. Even if Plaintiffs experience temporary reductions in the costs of the at-issue drugs from time to time, those costs still remain higher than they would have

been in a transparent and competitive market.

37. As payors and purchasers of the diabetes medications at issue, Plaintiffs, directly and/or through its agent, have been overcharged substantial amounts of money during the relevant period as a direct result of the Insulin Pricing Scheme.

38. A substantial portion of this amount is attributable to the artificially inflated prices of the at-issue drugs, which arose not from transparent or competitive market forces, but from undisclosed, opaque, and unlawful conduct on the part of the Manufacturer Defendants and the PBM Defendants.

39. This action alleges that Defendants violated the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1962(c), RICO, 18 U.S.C. § 1962(d), common law fraud, unjust enrichment, civil conspiracy, and Pennsylvania Unfair Trade Practices and Consumer Protection Law by engaging in the Insulin Pricing Scheme. The Insulin Pricing Scheme directly and foreseeably caused, and continues to cause, harm to Plaintiffs.

40. This action seeks injunctive relief, restitution, disgorgement, actual damages, statutory damages and/or penalties, punitive damages, attorneys' fees and costs, and all other available relief to address and abate the harm caused by the Insulin Pricing Scheme.

41. The relevant period for the claims alleged is from 2011 through the present.

II. PARTIES

A. Plaintiffs

42. Plaintiff Jefferson Health Corporation is a Pennsylvania non-profit health system headquartered in Philadelphia, Pennsylvania. Plaintiff Thomas Jefferson University is a private research university in Philadelphia, Pennsylvania. Plaintiffs are integrated entities and share a single board of directors.

43. Jefferson Health's mission is "to improve lives," and its operations date back to 1825. It has undergone several mergers, currently operating 32 hospitals and many other health care facilities in Pennsylvania and New Jersey. It has more than 58,0000 employees comprising of, among others, nurses, physicians and practitioners, and faculty. It is the second largest employer in Philadelphia and the largest health system in the Philadelphia region by total licensed beds.

44. During the relevant time period, Jefferson Health provided health benefits to Plaintiffs' employees, retirees, and their dependents ("Beneficiaries"). These benefits include paying for Beneficiaries' pharmaceutical drugs, including the diabetes medications at issue.

45. Plaintiffs self-insures the vast majority of its healthcare costs.

46. Jefferson Health also provided insulin and insulin-related drugs to patients in its hospitals and pharmacies during the relevant time period.

47. Any increase in spending has a detrimental effect on Plaintiffs' overall

budget and, in turn, negatively impacts its ability to provide necessary services to the Beneficiaries and the larger Philadelphia community.

48. The Insulin Pricing Scheme has had such an effect.

49. Plaintiffs maintain self-insured health plans for their employees and eligible retirees, which is administered by Independence Blue Cross (2017, 2018, 2023-2025), Aetna (2019, 2021, 2022), and PBMs including MedImpact (2017, 2018, 2019, 2020), Express Scripts (2021), Aetna (2021-2022) and CVS (2023-2025). The plan includes pharmacy benefits, meaning Plaintiffs purchased the insulin drugs at issue for the Beneficiaries, and contracted with a PBM to administer the pharmacy benefits. Operators of self-funded plans, like Plaintiffs, may be referred to as "payors," "plan sponsors," or "PBM clients."

50. Plaintiffs incurred and continues to incur significant costs by paying a substantial portion of the price of diabetes medications for its health-plan members. Accordingly, during the relevant period, and to the detriment of the Beneficiaries, Plaintiffs have paid substantially more for the insulin medications at issue than they otherwise would have paid absent Defendants' conduct.

51. Plaintiffs seek to recover for the losses they havesuffered as a result of Defendants' illegal Insulin Pricing Scheme.

B. Manufacturer Defendants

52. **Defendant Eli Lilly and Company ("Eli Lilly")** is an Indiana

corporation with its principal place of business at Lilly Corporate Center, Indianapolis, Indiana 46285.

53. Eli Lilly is registered to do business, among other places, in the Commonwealth of Pennsylvania and Eli Lilly transacts business in Pennsylvania, targeting this market for its products, including the at-issue diabetes medications.

54. In Pennsylvania and nationally, Eli Lilly manufactures, promotes, and distributes several diabetes medications, including: Humulin N (first U.S. approval in 1982), Humulin R (first U.S. approval in 1982), Humalog (first U.S. approval in 1996), Trulicity (first U.S. approval in 2014), and Basaglar (first U.S. approval in 2015).

55. Eli Lilly's domestic revenues from 2019 to 2021 were $11.9 billion from Trulicity, $4.48 billion from Humalog, $2.58 billion from Humulin and $2.31 billion from Basaglar.[13]

56. Eli Lilly's global revenues in 2018 were $3.2 billion from Trulicity, $2.99 billion from Humalog, $1.33 billion from Humulin and $801 million from Basaglar.

57. Eli Lilly employs sales representatives throughout Pennsylvania and in this District, to promote and sell diabetes medications, including Humulin N, Humulin R, Humalog, Trulicity, and Basaglar.

[13] Eli Lilly Annual Report (Form 10-K) (FYE Dec. 31, 2021).

58. Eli Lilly also directs advertising and informational materials to Pennsylvania physicians and consumers who are potential users of Eli Lilly's products.

59. At all times relevant hereto, in furtherance of the Insulin Pricing Scheme, Eli Lilly published its prices for the at-issue diabetes medications throughout Pennsylvania with the express knowledge that payment and reimbursement by Plaintiffs would be based on those false list prices.

60. During the relevant period, Plaintiffs purchased Eli Lilly's at-issue drugs at a price based on false list prices generated by the Insulin Pricing Scheme.

61. All Eli Lilly diabetes medications related to the at-issue transactions were paid for and/or reimbursed based on the specific false and inflated prices Eli Lilly caused to be published in Pennsylvania and elsewhere in furtherance of the Insulin Pricing Scheme.

62. **Defendant Sanofi-Aventis U.S. LLC ("Sanofi")** is a Delaware limited liability company with its principal place of business at 55 Corporate Drive, Bridgewater, New Jersey 08807.

63. Sanofi is registered to do business in the Commonwealth of Pennsylvania and transacts business in Pennsylvania, targeting this market for its products, including the at-issue diabetes medications.

64. Sanofi manufactures, promotes, and distributes pharmaceutical drugs

both in Pennsylvania and nationally, including Lantus (first U.S. approval in 2000), Apidra (first U.S. approval in April 2004), Toujeo (first U.S. marketing authorization in February 2015), and Soliqua (first U.S. approval in November 2016).

65. Sanofi touts Lantus as one of its "flagship products" and "one of Sanofi's leading products in 2021 with net sales of €2,494 million" ($2.95 billion), as well as net sales of €2,661 million ($3.04 billion) in 2020, representing 7.4% of the company's net sales for 2020.[14]

66. Sanofi's U.S. net sales in 2019 were $1.29 billion from Lantus, $323.7 million from Toujeo, and $51.5 million from Apidra.[15]

67. Sanofi employs sales representatives throughout Pennsylvania and in this District to promote and sell Lantus, Toujeo, Soliqua, and Apidra, and utilizes wholesalers to distribute the at-issue products to pharmacies and healthcare professionals within Pennsylvania.

68. Sanofi also directs advertising and informational materials to Pennsylvania physicians and consumers, who are potential users of Sanofi's products for the specific purpose of selling the at-issue drugs in Pennsylvania and profiting from the Insulin Pricing Scheme.

[14] Sanofi Annual Report (Form 20-F) (FYE Dec. 31, 2021); Sanofi Annual Report (Form 20-F) (FYE Dec. 31, 2020).

[15] Sanofi Annual Report (Form 20-F) (FYE Dec. 31, 2019).

69. At all times relevant hereto, in furtherance of the Insulin Pricing Scheme, Sanofi published its prices of its at-issue diabetes medications for the purpose of payment and reimbursement by payors, including Plaintiffs, through its agents.

70. During the relevant period, Plaintiffs purchased Sanofi's at-issue drugs at prices based on false list prices generated by the Insulin Pricing Scheme.

71. All Sanofi diabetes medications related to the at-issue transactions were paid for and/or reimbursed based on the specific false and inflated prices Sanofi caused to be published in furtherance of the Insulin Pricing Scheme.

72. **Defendant Novo Nordisk Inc. ("Novo Nordisk")** is a Delaware corporation with its principal place of business at 800 Scudders Mill Road, Plainsboro, New Jersey 08536.

73. Novo Nordisk is registered to do business in the Commonwealth of Pennsylvania and transacts business in Pennsylvania, targeting this market for its products, including the at-issue diabetes medications.

74. Novo Nordisk manufactures, promotes, and distributes pharmaceutical drugs both in Pennsylvania and nationally, including Novolin R (first U.S. approval in 1991), Novolin N (first U.S. approval in 1991), Novolog (first U.S. approval in June 2002), Levemir (first U.S. approval in June 2005), Victoza (first U.S. approval in January 2010), Tresiba (first U.S. approval in 2015), and Ozempic (first U.S.

approval in 2017).

75. Novo Nordisk's combined net sales of these drugs in the United States from 2018 to 2020 totaled approximately $18.1 billion ($6.11 billion for Victoza alone).[16]

76. Novo Nordisk's global revenues for "total diabetes care" over that three-year period exceeded $41 billion.[17]

77. Novo Nordisk employs sales representatives throughout Pennsylvania and this District to promote and sell Novolin R, Novolin N, Novolog, Levemir, Tresiba, Victoza, and Ozempic, and it utilizes wholesalers to distribute the at-issue products to pharmacies and healthcare professionals within Pennsylvania.

78. Novo Nordisk also directs advertising and informational materials to Pennsylvania physicians and consumers, who are potential users of Novo Nordisk's products.

79. At all times relevant hereto, in furtherance of the Insulin Pricing Scheme, Novo Nordisk published its prices of its at-issue diabetes medications throughout Pennsylvania for the purpose of payment and reimbursement by Plaintiffs.

80. During the relevant period, Plaintiffs purchased Novo Nordisk's at-issue

[16] Novo Nordisk, Annual Report (Form 20-F & Form 6-K) (FYE Dec. 31, 2020).

[17] *Id.*

diabetes medications at prices based on false list prices generated by the Insulin Pricing Scheme.

81. All Novo Nordisk diabetes medications related to the at-issue transactions were paid for and/or reimbursed based on the specific false and inflated prices Novo Nordisk caused to be published in furtherance of the Insulin Pricing Scheme.

82. Defendants Eli Lilly, Sanofi, and Novo Nordisk are referred to collectively as the "Manufacturer Defendants" or the "Manufacturers."

C. PBM Defendants

83. **Defendant CVS Health Corporation ("CVS Health")** is a Delaware corporation with its principal place of business at One CVS Drive, Woonsocket, Rhode Island 02895.

84. CVS Health transacts business and has locations throughout the United States and Pennsylvania and in this District.

85. CVS Health—through its executives and employees, including its CEO, Chief Medical Officer, Executive Vice Presidents, Senior Executives in Trade Finance, Senior Vice Presidents, and Chief Communication Officers—is directly involved in creating and implementing company policies that inform its PBM services and formulary construction, including with respect to the drugs involved in the Insulin Pricing Scheme.

86. CVS Health's (and its affiliate defendants) conduct had a direct effect in Pennsylvania and damaged Plaintiffs as a payor and purchaser.

87. On a regular basis, CVS Health executives and employees communicate with and direct its subsidiaries related to PBM services and formulary activities at issue.

88. In annual reports filed with the SEC throughout the last decade, CVS Health (or its predecessor) has repeatedly and explicitly stated that CVS Health itself:

- designs pharmacy benefit plans that minimize clients' costs while prioritizing the welfare and safety of its members;
- negotiates with pharmaceutical companies to obtain discounted acquisition costs for many of the products on CVS Health's drug lists, which enables CVS Health to offer reduced costs to clients; and
- utilizes an independent panel of doctors, pharmacists, and other medical experts, referred to as its Pharmacy and Therapeutics Committee, to select drugs that meet the highest standards of safety and efficacy for inclusion on its drug lists.

89. CVS Health publicly represents that it acts to lower the cost of the at-issue diabetes medications. In 2016 for example, CVS Health announced a new program to "reduce overall spending in diabetes" that is available in all states, including Pennsylvania, stating:

> *CVS Health* introduced a new program available to help the company's pharmacy benefit management (PBM) clients to improve the health outcomes of their members, *lower pharmacy costs [for diabetes medications]* through aggressive trend management and decrease medical costs . . . [and that] participating clients could save between $3,000 to $5,000 per year for each member who successfully improves

control of their diabetes" (emphasis supplied).[18]

90. A 2017 CVS Health report stated: "CVS Health pharmacy benefit management (PBM) strategies reduced trend for commercial clients to 1.9 percent per member per year the lowest in five years. Despite manufacturer price increases of near 10 percent, CVS Health kept drug price growth at a minimal 0.2 percent."

91. In November 2018, CVS Health acquired Aetna for $69 billion and became the first combined health insurer, PBM, and mail-order and retail pharmacy chain. CVS Health thus controls the health plan/insurer, the PBM, and the pharmacies used by approximately 40 million Aetna insurance members in the United States, including in Pennsylvania. CVS Health controls the entire drug payment chain for these 40 million Americans.

92. CVS Health is the direct or indirect parent of subsidiaries that own and operate hundreds of pharmacies throughout Pennsylvania, including CVS Pharmacy, Inc., which is registered to do business in the Commonwealth. These pharmacies dispensed and received payment for the at-issue diabetes medications throughout the relevant period. According to CVS Health's 2022 Form 10-K, the company "maintains a national network of approximately 66,000 retail pharmacies, consisting

[18] CVS HEALTH, *CVS Health Introduces New "Transform Diabetes Care" Program to Improve Health Outcomes and Lower Overall Health Care Costs*, Pharmacy Times (Dec. 13, 2016), https://www.pharmacytimes.com/view/cvs-health-introduces-new-transform-diabetes-care-program-to-improve-health-outcomes-and-lower-overall-health-care-costs (last visited Dec. 11, 2025).

of approximately 40,000 chain pharmacies (which include CVS Pharmacy locations) and approximately 26,000 independent pharmacies, in the United States."[19]

93. **Defendant CVS Pharmacy, Inc. ("CVS Pharmacy")** is a Rhode Island corporation whose principal place of business is at One CVS Drive, Woonsocket, Rhode Island 02895, the same location as CVS Health. CVS Pharmacy is a wholly-owned subsidiary of CVS Health and is registered to do business in Pennsylvania.

94. CVS Pharmacy is the immediate or indirect parent of many subsidiaries that own and operate hundreds of pharmacies throughout Pennsylvania and is directly involved in these pharmacies dispensing and payment policies related to the at-issue diabetes medications.

95. CVS Pharmacy holds numerous pharmacy licenses (d/b/a CVS Health) in Pennsylvania.

96. During the relevant period, CVS Pharmacy provided retail pharmacy services in Pennsylvania that gave rise to the Insulin Pricing Scheme, which damaged payors, including Plaintiffs, through its agent.

97. CVS Pharmacy is also the immediate and direct parent of Defendant Caremark Rx, LLC.

98. **Defendant Caremark Rx, LLC** is a Delaware limited liability

[19] CVS Health Annual Report (Form 10-K) (FYE Dec. 31, 2022).

company and an immediate or indirect parent of many subsidiaries, including pharmacy benefit management and mail-order subsidiaries that engaged in the activities in Pennsylvania that gave rise to this action.

99. Caremark Rx, LLC is an indirect subsidiary of Defendant CVS Health, and its principal place of business is at the same location as CVS Pharmacy and CVS Health.

100. Caremark Rx, LLC is registered to do business in Pennsylvania.

101. During the relevant period, Caremark Rx, LLC provided PBM and mail-order pharmacy services in Pennsylvania that gave rise to the Insulin Pricing Scheme and damaged payors in Pennsylvania, including Plaintiffs, through its agents.

102. **Defendant Caremark, LLC** is a California limited liability company whose principal place of business is at the same location as CVS Health.

103. Caremark, LLC is a subsidiary of Caremark Rx, LLC, which is a subsidiary of Defendant CVS Pharmacy, which itself is a wholly owned subsidiary of Defendant CVS Health. Caremark, LLC holds numerous pharmacy licenses, including in Pennsylvania.

104. During the relevant period, Caremark, LLC provided PBM and mail-order pharmacy services in Pennsylvania that gave rise to the Insulin Pricing Scheme, which damaged payors, including Plaintiffs.

105. **Defendant CaremarkPCS Health, LLC ("CaremarkPCS Health")**

is a Delaware limited liability company whose principal place of business is at the same location as CVS Health and is registered to do business in Pennsylvania.

106. CaremarkPCS Health is an indirect subsidiary Caremark Rx, LLC, which is a subsidiary of Defendant CVS Pharmacy, which is a wholly owned subsidiary of Defendant CVS Health.

107. CaremarkPCS Health provides pharmacy benefit management services.

108. During the relevant period, CaremarkPCS Health provided PBM services in Pennsylvania, which gave rise to the Insulin Pricing Scheme and damaged payors, including Plaintiffs.

109. During the relevant period, CaremarkPCS Health played a critical role in the Insulin Pricing Scheme, which detrimentally affected all payors and purchasers of the at-issue drugs, including Plaintiffs, through its agents.

110. **Defendant Zinc Health Services, LLC** ("Zinc") is a Delaware limited liability company with its principal place of business at One CVS Drive, Woonsocket, Rhode Island 02895.

111. Zinc is a direct subsidiary of CVS Pharmacy, which is a direct subsidiary of CVS Health.

112. CVS Health established Zinc as a GPO for CVS Caremark's PBM business in March 2020. Zinc was founded, at least in part, to negotiate rebates with drug manufacturers and upon information and belief, Zinc negotiated rebates with

the Manufacturers for at-issue drugs sold and distributed in Pennsylvania during the time period at issue.

113. Defendants CaremarkPCS Health, Caremark, LLC, and Zinc are agents and/or alter egos of Caremark Rx, LLC, CVS Pharmacy, and CVS Health.

114. As a result of shared headquarters, executives and numerous interlocking directorships, Caremark Rx, LLC, CVS Pharmacy, and CVS Health are directly involved in the conduct of and control CaremarkPCS Health's and Caremark, LLC's operations, management, and business decisions related to the at-issue formulary construction; Manufacturer Payments; and mail-order and retail pharmacy services—to the ultimate detriment of Plaintiffs. For example:

- During the relevant period, these parents and subsidiaries have had common officers and directors, including:
    - Thomas S. Moffatt, Vice President and Secretary of Caremark Rx, LLC, CaremarkPCS Health, and Caremark, LLC, has also served as Vice President, Assistant Secretary, and Senior Legal Counsel at CVS Health and the Vice President, Secretary and Senior Legal Counsel of CVS Pharmacy;
    - Melanie K. Luker, Assistant Secretary of Caremark Rx, LLC, CaremarkPCS Health, and Caremark, LLC, has also served as Manager of Corporate Services at CVS Health;
    - Carol A. Denale, Senior Vice President and Treasurer of Caremark Rx, LLC, has also served as Senior Vice President, Treasurer, and Chief Risk Officer at CVS Health Corporation;
    - John M. Conroy has been Vice President of Finance at CVS

Health since 2011, and has also served as President and Treasurer of Caremark, LLC and CaremarkPCS Health in 2019; and

- Sheelagh Beaulieu has been the Senior Director of Income Tax at CVS Health while also acting as the Assistant Treasurer at CaremarkPCS Health and Caremark, LLC.

- CVS Health owns CVS Pharmacy, which owns Caremark Rx, LLC, which owns Caremark LLC. CVS Health directly or indirectly owns CaremarkPCS Health in its entirety.

- CVS Health, as a corporate unit, does not operate as separate entities. Rather, its public filings, documents and statements present its subsidiaries—including CVS Pharmacy, Caremark Rx, LLC, Caremark, LLC, and CaremarkPCS Health—as divisions or departments of one unified "diversified health services company" that "works together across our disciplines" to "create unmatched human connections to transform the health care experience." CVS Health's public filings also provide that the company "operates a group purchasing organization that negotiates pricing for the purchase of pharmaceuticals and rebates with pharmaceutical manufacturers on behalf of its participants," (although it does not identify Zinc by name).[20] The day-to-day operations of this corporate unit reflect these public statements. These

[20] CVS Health Corp. Annual Report (Form 10-K) (FYE Dec. 31, 2020-2023).

entities constitute a single business enterprise and should be treated as such as to all legal obligations discussed in this Complaint.[21]

- Upon information and belief, the executives of CaremarkPCS Health, Caremark, LLC, Caremark Rx, LLC, CVS Pharmacy and Zinc ultimately report to the executives at CVS Health, including its President and CEO.
- CVS Health's CEO, Chief Medical Officer, Executive Vice Presidents, Senior Executives in Trade Finance, Senior Vice Presidents and Chief Communication Officers are directly involved in Caremark, LLC's and CaremarkPCS's policies and business decisions that give rise to Plaintiffs' claims.

115. Defendants CVS Health, CVS Pharmacy, Caremark Rx, LLC, Caremark, LLC, CaremarkPCS Health, and Zinc including all predecessor and successor entities, are referred to collectively as "CVS Caremark."

116. CVS Caremark is named as a Defendant in all of its capacities — as a PBM, a rebate aggregator, and as a mail-order pharmacy.

117. In its capacity as a PBM, CVS Caremark coordinated with Novo

[21] CVS Caremark/CVS Health, Annual Report (Form 10-K) (FYE Dec. 31, 2009-2019); CVS Health, *Our Purpose*, https://cvshealth.com/about-cvs-health/our-purpose (last visited Dec. 15, 2025).

Nordisk, Eli Lilly, and Sanofi regarding the price of the at-issue diabetes medications, as well as for the placement of these diabetes medications on CVS Caremark's formularies.

118. CVS Caremark has the largest PBM market share based on total prescription claims managed. Its pharmacy-services segment provides, among other things, plan design offerings and administration, formulary management, retail pharmacy network management services, mail-order pharmacy, specialty pharmacy and infusion services, clinical services, and medical spend management. In 2021, CVS Caremark's pharmacy services segment "surpassed expectations" and had a "record selling season of nearly $9 billion in net new business wins for 2022." In all, it generated just over $153 billion in total revenues (on top of total 2019-2020 segment revenues exceeding $283 billion).[22]

119. At all relevant times, CVS Caremark offered pharmacy benefit services nationwide and to Pennsylvania payors, and derived substantial revenue from those services, and, in doing so, (a) made misrepresentations while concealing the Insulin Pricing Scheme, and (b) used the false prices generated by the Insulin Pricing Scheme.

120. At all relevant times, CVS Caremark offered PBM services nationwide and maintained standard formularies that were used nationwide, including in

[22] CVS Health Annual Report (Form 10-K) (FYE Dec. 31, 2021).

Pennsylvania. Those formularies contained diabetes medications, including those at issue in this action, and CVS Caremark participated in pricing the at-issue drugs based off of list prices it knew to be false.

121. CVS Caremark purchased drugs directly from manufacturers for dispensing through its pharmacy network.

122. In its capacity as a retail pharmacy, CVS Caremark knowingly profited from the false list prices generated by the Insulin Pricing Scheme by retaining the spread between its acquisition cost for the at-issue drugs—an amount well below the inflated list prices—and the amounts it received from payors, which were based on those false list prices and, in many instances, set by CVS Caremark in its capacity as a PBM.

123. During the relevant period, CVS Caremark provided mail-order and retail pharmacy services nationwide and within Pennsylvania and employed prices based on the false list prices generated by the Insulin Pricing Scheme.

124. At all relevant times, CVS Caremark dispensed the at-issue medications nationwide and within the State of Pennsylvania through its mail-order and retail pharmacies and it derived substantial revenue from these activities in Pennsylvania.

125. At all times relevant, CVS Caremark had agreements with Novo Nordisk, Sanofi, and Eli Lilly related to the Manufacturer Payments paid by the

Manufacturer Defendants to CVS Caremark, as well as agreements related to the Manufacturers' at-issue drugs sold through CVS Caremark's mail-order pharmacies.

126. **Defendant Evernorth Health, Inc. ("Evernorth"),** was formerly known as Express Scripts Holding Company, and is a Delaware corporation with its principal place of business at One Express Way, St. Louis, Missouri 63121.[23]

127. Evernorth, through its executives and employees, including its CEO and Vice Presidents, is directly involved in shaping the company policies that inform its PBM services and formulary construction, including with respect to the diabetes medications at issue and the Insulin Pricing Scheme.

128. Evernorth's conduct has had a direct effect in Pennsylvania.

129. On a regular basis, Evernorth executives and employees communicate with and direct Evernorth's subsidiaries related to the at-issue PBM services and formulary activities.

130. Evernorth is the immediate or indirect parent of pharmacy and PBM subsidiaries that operate throughout Pennsylvania, which engaged in the activities that gave rise to this action.

131. In 2018, Evernorth merged with Cigna in a $67 billion deal to

[23] Until 2021, Evernorth Health, Inc. conducted business under the name Express Scripts Holding Company. For the purposes of this Complaint "Evernorth" refers to Evernorth Health, Inc. and Express Scripts Holding Company.

consolidate their businesses as a major health insurer, PBM, and mail-order pharmacy. As a result, the Evernorth corporate family controls the health plan/insurer, the PBM, and the mail-order pharmacies used by approximately 15 million Cigna members in the United States, including in Pennsylvania. Evernorth controls the entire drug payment chain for these 15 million Americans.

132. In annual reports filed with the SEC throughout the last decade, Evernorth repeatedly and explicitly:

- Acknowledged that it is directly involved in the company's PBM services, stating "[Evernorth is] the largest stand-alone PBM company in the United States."

- Stated that Evernorth: "provid[es] products and solutions that focus on improving patient outcomes and assist in controlling costs; evaluat[es] drugs for efficacy, value and price to assist clients in selecting a cost-effective formulary; [and] offer[s] cost-effective home delivery pharmacy and specialty services that result in cost savings for plan sponsors and better care for members."

133. Even after the merger with Cigna, Evernorth "operates various group purchasing organizations that negotiate pricing for the purchase of pharmaceuticals and formulary rebates with pharmaceutical manufacturers on behalf of their participants" and operates the company's Pharmacy Rebate Program. At the same time, its subsidiary, Defendant Express Scripts, Inc. provides "formulary management services" that ostensibly "assist customers and physicians in choosing clinically-appropriate, cost-effective drugs and prioritize access, safety and affordability." In 2021, Evernorth reported adjusted revenues of $131.9 billion

(representing 75.8% of Cigna Corporation's revenues), up from $116.1 billion in 2020.[24]

134. **Defendant Express Scripts, Inc.** is a Delaware corporation and is a wholly-owned subsidiary of Defendant Evernorth. Express Scripts, Inc.'s principal place of business is at the same location as Evernorth.

135. Express Scripts, Inc. is registered to do business in Pennsylvania.

136. Express Scripts, Inc. is the immediate or indirect parent of pharmacy and PBM subsidiaries that operate throughout Pennsylvania that engaged in the conduct that gave rise to this action.

137. During the relevant period, Express Scripts Inc. was directly involved in the PBM and mail-order pharmacy services that gave rise to the Insulin Pricing Scheme and damaged payors.

138. **Defendant Express Scripts Administrators, LLC**, formerly known as Medco Health, LLC, is a Delaware limited liability company and is a wholly owned subsidiary of Evernorth. Express Scripts Administrators, LLC's principal place of business is at One Express Way, St. Louis, Missouri 63121—the same location as Evernorth.

139. During the relevant period, Express Scripts Administrators, LLC provided the PBM services in Pennsylvania discussed in this Complaint that gave

[24] Cigna Annual Report (Form 10-K) (FYE Dec. 31, 2021)

rise to the Insulin Pricing Scheme that damaged payors, including Plaintiffs, directly and/or through its agents.

140. **Defendant Medco Health Solutions, Inc. ("Medco")** is a Delaware Corporation with its principal place of business located at the same address as Evernorth. Until its acquisition by Express Scripts, Inc.**,** Medco's principal place of business was in Franklin Lakes, New Jersey.

141. In 2012, Express Scripts, Inc. acquired Medco for $29 billion.

142. Before the merger, Express Scripts, Inc. and Medco were two of the largest PBMs in the United States and in Pennsylvania.

143. Before the merger, Medco provided the at-issue PBM and mail-order services in Pennsylvania, which gave rise to the Insulin Pricing Scheme and damaged payors.

144. Following the merger, all of Medco's PBM and mail-order pharmacy functions were combined into Express Scripts. The combined company (Medco and Express Scripts, Inc.) continued under the name Express Scripts, Inc. with all of Medco's payor customers becoming Express Scripts Inc.'s customers. The combined company covered over 155 million lives at the time of the merger.

145. At the time of the merger, on December 6, 2011, David Snow, then-CEO of Medco, publicly represented in his testimony before the Senate Judiciary Committee that "the merger of Medco and Express Scripts will result in immediate

savings to our clients and, ultimately, to consumers. This is because our combined entity will achieve even greater purchasing volume discounts [i.e., Manufacturer Payments] from drug manufacturers and other suppliers."[25]

146. At the same time, the then-CEO of Express Scripts, Inc., George Paz, provided written testimony to the Senate Judiciary Committee's Subcommittee on Antitrust, Competition Policy and Consumer Rights, stating: "A combined Express Scripts and Medco will be well-positioned to protect American families from the rising cost of prescription medicines." First on Mr. Paz's list of "benefits of this merger" was "[g]enerating greater cost savings for patients and plan sponsors."[26]

147. **Defendant ESI Mail Pharmacy Service, Inc.** is a Delaware corporation and is a wholly owned subsidiary of Defendant Evernorth. ESI Mail Pharmacy Service, Inc.'s principal place of business is the same location as Evernorth.

148. During the relevant period, ESI Mail Pharmacy Service, Inc. provided

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[25] David B. Snow, Jr., *Testimony Before the Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy and Consumer Rights* (Dec. 6, 2011) at 11, available at https://www.judiciary.senate.gov/imo/media/doc/11-12-6SnowTestimony.pdf (last visited Dec. 15, 2025).

[26] George Paz, *Written Testimony of George Paz, Chairman and Chief Executive Officer, Express Scripts Inc., before the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy and Consumer Rights, Hearing on the Proposed Merger between Express Scripts and Medco* (Dec. 6, 2011) at 8, available at https://www.judiciary.senate.gov/imo/media/doc/11-12-6PazTestimony.pdf (last visited Dec. 15, 2025).

the mail-order pharmacy services in Pennsylvania discussed in this Complaint, which gave rise to the Insulin Pricing Scheme and damaged payors.

149. **Defendant Express Scripts Pharmacy, Inc.** is a Delaware corporation and is a wholly owned subsidiary of Defendant Evernorth. Express Scripts Pharmacy, Inc.'s principal place of business is at the same location as Evernorth.

150. Express Scripts Pharmacy, Inc. is registered to do business in Pennsylvania.

151. During the relevant period, Express Scripts Pharmacy, Inc. provided the mail-order pharmacy services in Pennsylvania discussed in this Complaint, which gave rise to the Insulin Pricing Scheme and damaged payors.

152. **Defendant Ascent Health Services LLC** ("Ascent") is a Delaware limited liability company with its principal place of business at Mühlentalstrasse 36, 8200 Schaffhausen, Switzerland.

153. Ascent is part of Evernorth and a subsidiary of Cigna Corporation.

154. Express Scripts, Inc. established Ascent in 2019 as a GPO for their PBM business. Ascent was founded, at least in part, to negotiate rebates with drug manufacturers for Express Scripts, Inc. and now performs this service for them and third-party clients.

155. During the relevant period, Ascent negotiated rebates with the Manufacturers for at-issue drugs sold and distributed in Pennsylvania.

156. As a result of numerous interlocking directorships and shared executives, Evernorth (f/k/a Express Scripts Holding Company, Inc.) and Express Scripts, Inc. control Express Scripts Administrators, LLC's, ESI Mail Pharmacy Service, Inc.'s, Medco Health Solutions, Inc.'s, Express Scripts Pharmacy, Inc.'s, and Ascent's operations, management, and business decisions related to the at-issue formulary construction, negotiations, and mail-order pharmacy services to the ultimate detriment of payors. For example:

- During the relevant period, these entities have had common officers and directors. All of the executives of Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc., Express Scripts, Inc., and Ascent ultimately report to the executives, including the CEO, of Evernorth.
- Upon information and belief, Evernorth directly or indirectly owns all the stock or otherwise controls Express Scripts Administrators, LLC, Medco Health Solutions, Inc., ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc., Express Scripts, Inc., and Ascent.[27]
- As stated above, Evernorth's CEO and other executives and officers are directly involved in the policies and business decisions of Express

[27] Express Scripts Annual Report (Form 10-K, Exhibit 21) (FYE Dec. 31, 2018).

Scripts Administrators, LLC; ESI Mail Pharmacy Service, Inc.; Medco Health Solutions, Inc.; Express Scripts Pharmacy, Inc.; Express Scripts, Inc.; and Ascent, that gave rise to Plaintiffs' claims in this Complaint.

- Upon information and belief, the Evernorth corporate family does not operate as separate entities. Evernorth's public filings, documents, and statements present its subsidiaries, including Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc., Express Scripts, Inc., and Ascent, as divisions or departments of a single company that "unites businesses that have as many as 30+ years of experience . . . [to] tak[e] health services further with integrated data and analytics that help us deliver better care to more people." The day-to-day operations of this corporate family reflect these public statements. All of these entities comprise a single business enterprise and should be treated as such as to all legal obligations detailed in this Complaint.

157. Defendants Evernorth Health, Inc., Express Scripts, Inc., Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Medco Health Solutions, Inc., Express Scripts Pharmacy, Inc., and Ascent—including all predecessor and successor entities—are referred to collectively as "Express Scripts."

158. Express Scripts is named as a Defendant in its capacities as a PBM, rebate aggregator and mail-order pharmacy.

159. In its capacity as a PBM, Express Scripts coordinates with Novo Nordisk, Eli Lilly, and Sanofi regarding the price of the at-issue diabetes medications, as well as for the placement of these Manufacturers' diabetes medications on Express Scripts' formularies.

160. Before merging with Cigna, Express Scripts was the largest independent PBM in the United States.[28] During the period covered by this Complaint, Express Scripts controlled up to 30% of the PBM market in the United States.

161. The Express Scripts network offers more than 68,000 retail pharmacies nationwide, including in Pennsylvania.

162. Express Scripts transacts business throughout the United States and Pennsylvania.

163. At all times relevant hereto, Express Scripts derived substantial revenue from providing retail and mail-order pharmacy benefits in Pennsylvania.

164. At all times relevant hereto, and contrary to its express representations, Express Scripts knowingly insisted that its payor clients use the artificially inflated prices produced by the Insulin Pricing Scheme as the basis for reimbursement of the at-issue drugs.

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[28] *Id.*

165. At all times relevant hereto, Express Scripts concealed its critical role in generating those artificially inflated list prices.

166. At all times relevant, Express Scripts maintained standard formularies that are used nationwide, including in Pennsylvania. During the relevant time period, those formularies included drugs produced by the Manufacturer Defendants, including the at-issue diabetes medications.

167. In its capacity as a mail-order pharmacy, Express Scripts received payments from Pennsylvania payors for, and set the out-of-pocket price paid for, the at-issue drugs based on the artificially inflated prices generated by the Insulin Pricing Scheme and, as a result, damaged Plaintiffs.

168. At all times relevant, Express Scripts offered pharmacy benefit management services nationwide and maintained standard formularies that are used nationwide, including in Pennsylvania. During the relevant period, those formularies included diabetes medications, including all of those at issue in this Complaint.

169. Express Scripts purchases drugs directly from manufacturers for dispensing through its mail-order pharmacy.

170. During the years when some of the largest at-issue price increases occurred, Express Scripts worked directly with OptumRx, Inc. to negotiate Manufacturer Payments on behalf of OptumRx, Inc. and its clients in exchange for preferred formulary placement.

171. For example, in a February 2014 email released by the U.S. Senate in conjunction with its January 2021 report titled "Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug" ("January 2021 Senate Insulin Report"), Eli Lilly describes a "Russian nested doll situation" in which Express Scripts was negotiating rebates on behalf of OptumRx, Inc. related to the at-issue drugs for Cigna (which later would become part of Express Scripts).[29]

172. At all relevant times, Express Scripts had express agreements with Defendants Novo Nordisk, Sanofi, and Eli Lilly related to the Manufacturer Payments paid by the Manufacturer Defendants to Express Scripts, as well as agreements related to the Manufacturers' at-issue drugs sold through Express Scripts' pharmacies.

173. **Defendant UnitedHealth Group, Inc**. **("UnitedHealth Group")** is a corporation organized under the laws of Delaware with its principal place of business at 9900 Bren Road East, Minnetonka, Minnesota, 55343.

174. UnitedHealth Group is a diversified managed healthcare company. In 2022, it reported revenues in excess of $324 billion, and the company currently ranks

[29] Letter from Joseph B. Kelley to Charles E. Grassley & Ron Wyden, S. Fin. Comm., available at https://www.finance.senate.gov/imo/media/doc/Eli%20Lilly_Redacted%20v1.pdf (last visited Dec. 15, 2025); *see generally* Senate Insulin Report *supra* note 7.

third on the Fortune 500 list.[30] UnitedHealth Group offers a spectrum of products and services including health insurance plans through its wholly owned subsidiaries and prescription drugs through its PBM, OptumRx, Inc.

175. A substantial portion of the overall revenues of UnitedHealth Group comes from OptumRx, Inc.

176. UnitedHealth Group, through its executives and employees, is directly involved in the company policies that shape its PBM services and formulary construction, including with respect to the at-issue drugs and related to the Insulin Pricing Scheme. For example, UnitedHealth Group executives structure, analyze, and direct the company's overarching policies, including with respect to PBM and mail-order services, as a means of maximizing profitability across the corporate family.

177. In addition to being a PBM and a mail-order pharmacy, UnitedHealth Group owns and controls a major health insurance company, UnitedHealthcare. As a result, UnitedHealth Group controls the health plan/insurer, the PBM, and the mail-order pharmacies used by approximately 26 million UnitedHealthcare members in the United States. UnitedHealth Group controls the entire drug payment chain for these 26 million Americans.

[30] UnitedHealth Group, Inc. Annual Report (Form 10-K) (FYE Dec. 31, 2022); Full List of Fortune 500 Companies, available at https://us500.com/fortune-500-companies. (last visited Dec. 15, 2025).

178. UnitedHealth Group's conduct had a direct effect in Pennsylvania and damaged Plaintiffs.

179. Its 2022 annual report states that it is "involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members …." As of year-end 2022 and 2021, UnitedHealth Group's "total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to $8.2 billion and 7.2, respectively," up even from $6.3 billion in 2020."[31]

180. **Defendant Optum, Inc.** is a Delaware corporation with its principal place of business in Eden Prairie, Minnesota. Optum, Inc. is a health services company managing subsidiaries that administer pharmacy benefits, including Defendant OptumRx, Inc.

181. Optum, Inc. is directly involved, through its executives and employees, in the company policies that inform its PBM services and formulary construction, including with respect to the at-issue drugs and related to the Insulin Pricing Scheme, which had a direct effect in Pennsylvania.

182. **Defendant OptumRx, Inc.** is a California corporation with its principal

[31] UnitedHealth Group Annual Report (Form 10-K) (FYE Dec. 31, 2018); UnitedHealth Group Annual Report (Form 10-K, Ex. 21) (FYE Dec. 31, 2021-2022)

place of business at 2300 Main Street, Irvine, California, 92614.

183. OptumRx, Inc. operates as a subsidiary of OptumRx Holdings, LLC, which, in turn, operates as a subsidiary of Defendant Optum, Inc.

184. OptumRx, Inc. is registered to do business in Pennsylvania.

185. During the relevant period, OptumRx, Inc. provided the PBM and mail-order pharmacy services in Pennsylvania that gave rise to the Insulin Pricing Scheme, which damaged Plaintiffs.

186. **Defendant OptumInsight, Inc. ("OptumInsight")** is a Delaware corporation with its principal place of business located in Eden Prairie, Minnesota.

187. OptumInsight is registered to do business in Pennsylvania. OptumInsight is an integral part of the Insulin Pricing Scheme and, during the relevant time period, coordinated directly with the Manufacturer Defendants in furtherance of the conspiracy. OptumInsight analyzed data and other information from the Manufacturer Defendants to advise the other Defendants regarding the profitability of the Insulin Pricing Scheme to the benefit of all Defendants.

188. **Defendant Emisar Pharma Services LLC** ("Emisar") is a Delaware limited liability company with its principal place of business 1 Optum Circle, Eden Prairie, Minnesota 55344 and operations in the United States and Ireland.

189. Emisar is a wholly owned indirect subsidiary of UnitedHealth Group Inc.

190. Optum established Emisar in June 2021 as a GPO for Optum's PBM business. Emisar negotiates rebates with drug manufacturers on behalf of Optum's commercial clients.

191. During the relevant period, Emisar negotiated rebates with the Manufacturers for at-issue drugs sold and distributed in Pennsylvania.

192. As a result of numerous interlocking directorships and shared executives, UnitedHealth Group, OptumRx Holdings, LLC, and Optum, Inc. are directly involved in the conduct of and control OptumInsight's and Optum Rx, Inc.'s operations, management, and business decisions related to the at-issue formulary construction, negotiations, and mail-order pharmacy services to the ultimate detriment of Plaintiffs. For example:

- During the relevant time period, these parent companies and subsidiaries have common officers and directors.
- Upon information and belief, UnitedHealth Group directly or indirectly owns all the stock of Optum, Inc., OptumRx, Inc., OptumInsight, and Emisar;
- Upon information and belief, the entities comprising the UnitedHealth Group corporate family do not operate as separate entities. The public filings, documents, and statements of UnitedHealth Group present its subsidiaries, including Optum, Inc., OptumRx, Inc., OptumInsight and

Emisar as divisions, departments, or "segments" of a single company that is "a diversified family of businesses" and that "leverages core competencies" to "help[] people live healthier lives and helping make the health system work better for everyone." The day-to-day operations of this corporate family reflect these public statements. These entities are a single business enterprise and should be treated as such as to all legal obligations detailed in this Complaint.[32]

- All executives of Optum, Inc., OptumRx, Inc., OptumInsight and Emisar—including the CEOs—ultimately report to the executives, of UnitedHealth Group.
- As stated above, UnitedHealth Group's executives and officers are directly involved in the policies and business decisions of Optum, Inc., OptumRx, Inc., OptumInsight and Emisar that gave rise to Plaintiffs' claims in this Complaint.

193. Defendants UnitedHealth Group, Inc., OptumRx, Inc., OptumInsight, Inc., Optum, Inc., and Emisar, including all predecessor and successor entities, are collectively referred to as "OptumRx."

194. OptumRx is named as a Defendant in its capacities as a PBM, rebate

[32] UnitedHealth Group, Quarterly Report (Form 10-Q) (Mar. 31, 2017).

aggregator, and mail-order pharmacy.

195. OptumRx is a pharmacy benefit manager and, as such, coordinates with Novo Nordisk, Eli Lilly, and Sanofi regarding the price of the at-issue diabetes medications, as well as for the placement of these Manufacturers' diabetes medications on OptumRx's drug formularies.

196. OptumRx provides pharmacy care services to more than 65 million people in the nation through a network of more than 67,000 retail pharmacies and multiple delivery facilities.

197. In 2023, OtpumRx managed $159 billion in pharmaceutical spending.[33]

198. In 2022, OptumRx managed $124 billion in pharmaceutical spending.[34]

199. At all times relevant, OptumRx derived substantial revenue providing pharmacy benefits in Pennsylvania.

200. At all times relevant, OptumRx offered pharmacy benefit management services nationwide and maintained standard formularies that are used nationwide, including in Pennsylvania. During the relevant time period, those formularies included diabetes medications, including all of those at issue in this Complaint.

201. At all times relevant, and contrary to its express representations,

[33] UnitedHealth Group Inc., Annual Report (Form 10-K) (Dec. 31, 2023).

[34] UnitedHealth Group Annual Report (Form 10-K) (FYE Dec. 31, 2022)

OptumRx knowingly insisted that its payor clients use the artificially inflated list prices produced by the Insulin Pricing Scheme as the basis for reimbursement of the at-issue drugs.

202. At all times relevant, OptumRx concealed its critical role in the generation of those artificially inflated list prices.

203. In its capacity as a mail-order pharmacy with a contracted network of retail pharmacies, OptumRx received payments from payors, or their agents, for, and set the out-of-pocket price paid for, the at-issue drugs based on the artificially inflated prices produced by the Insulin Pricing Scheme and, as a result, damaged Plaintiffs.

204. At all times relevant, OptumRx dispensed the at-issue medications nationwide and in Pennsylvania through its mail-order pharmacies and derived substantial revenue from these activities in Pennsylvania.

205. OptumRx purchases drugs produced by the Manufacturer Defendants, including the at-issue diabetes medications, for dispensing through its mail-order pharmacies and network of retail pharmacies.

206. At all times relevant, OptumRx had express agreements with Novo Nordisk, Sanofi, and Eli Lilly related to the Manufacturer Payments paid by the Manufacturer Defendants to OptumRx, as well as agreements related to the Manufacturers' at-issue drugs sold through OptumRx pharmacies.

207. Collectively, and as set forth below, CVS Caremark, Express Scripts,

and OptumRx are referred to as the "PBM Defendants" or the "PBMs."

III. JURISDICTION AND VENUE

A. Subject-Matter Jurisdiction

208. This action is directly filed in In Re: Insulin Pricing Litigation, MDL No. 3080, which was established on August 3, 2023, pursuant to the United States Judicial Panel on Multidistrict Litigation transfer order, and in accordance with Case Management Order #9. This Court has subject-matter jurisdiction pursuant to 28 U.S.C. § 1331 and pursuant to 18 U.S.C. § 1964(c) because this action alleges violations of the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1962, which raises a federal question. This Court has supplemental jurisdiction over the state law claims in this action pursuant to 28 U.S.C. § 1367.

209. There is also federal subject matter jurisdiction over this action because complete diversity exists among the parties, 28 U.S.C. § 1332. The parties are citizens of different states, and the amount in controversy, exclusive of interests or costs, exceeds the sum or value of $75,000.

B. Personal Jurisdiction

210. This Court has personal jurisdiction over each Defendant. Each Defendant: (a) transacts business and/or is registered to conduct business in Pennsylvania, (b) maintains substantial contacts in Pennsylvania, and (c) committed the violations of Pennsylvania statutes, federal statutes, and common law at issue in this lawsuit in whole or part within Pennsylvania.

211. The Insulin Pricing Scheme has been directed at the Commonwealth of Pennsylvania and has had the foreseeable and intended effect of causing injury to persons residing in, located in, or doing business in Pennsylvania, including Plaintiffs. All transactions at issue occurred in Pennsylvania or involved Pennsylvania residents.

212. Each Defendant has purposefully availed itself of the privilege of doing business within Pennsylvania, including within this District; and each has derived substantial financial gain from doing so. These continuous, systematic, and case-related business contacts—including the tortious acts described herein—are such that each Defendant should reasonably have anticipated being brought into this Court.

213. Each Defendant submitted itself to jurisdiction through, among other things, pervasive marketing; encouraging the use of its services; and its purposeful cultivation of profitable relationships in Pennsylvania.

214. In short, each Defendant has systematically served a market in Pennsylvania relating to the Insulin Pricing Scheme and has caused injury in Pennsylvania such that there is a strong relationship among Defendants, this forum, and the litigation.

215. This Court has personal jurisdiction over all Defendants pursuant to Fed. R. Civ. P. 4(k)(1)(A) because they would be subject to the jurisdiction of a court of

general jurisdiction in Pennsylvania.

216. This Court also has personal jurisdiction over all Defendants under 18 U.S.C. § 1965(b). This Court may exercise nationwide jurisdiction over the named Defendants where the "ends of justice" require national service and Plaintiffs demonstrate national contacts. Here, the interests of justice require that Plaintiffs be allowed to bring all members of the nationwide RICO enterprises described herein before the Court in a single action for a single trial.

C. Venue

217. Venue is proper pursuant to 18 U.S.C. § 1965 because all Defendants reside, are found, have an agent, or transact their affairs in this District, and the ends of justice require that any Defendant residing elsewhere be brought before this Court. In particular at all times relevant, Defendants provided pharmacy benefit services, provided mail-order pharmacy services, employed sales representatives, promoted and sold diabetes medications, and published prices of the at-issue drugs in this District.

218. Venue is also proper in this District pursuant to U.S.C. § 1391(b) and (c) because all Defendants transacts business in, are found in, and/or have agents in this District, and because some of the actions giving rise to the Complaint took place within this District.

IV. ADDITIONAL FACTUAL ALLEGATIONS

A. Diabetes and Insulin Therapy

1. *The Diabetes Epidemic*

219. Diabetes occurs when a person's blood glucose is too high. In people without diabetes, the pancreas secretes the hormone insulin, which controls the rate at which food is converted to blood glucose. When insulin is lacking or when cells stop responding to insulin, however, blood sugar stays in the bloodstream. Over time, this can cause serious health problems, including heart disease, blindness, and kidney disease. Diabetes-related complications are the eighth leading cause of death in the United States.[35]

220. It is estimated 38.4 million people in the United States, or 11.6 percent of the population, had diabetes and that number continues to grow.[36] There are two basic types of diabetes: Type 1 and Type 2.

- Type 1: Approximately 5-10% of diabetics are Type 1, which occurs when a person's pancreas does not make—or makes very little—

[35] Am. Diabetes Assoc., Statistics About Diabetes, https://diabetes.org/about-diabetes/statistics/about-diabetes (last visited Dec. 16, 2025).

[36] CDC, National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, Centers for Disease Control and Prevention (May 15, 2024), https://www.cdc.gov/diabetes/php/data-research/index.html (last visited Dec. 16, 2025).

insulin. Those with Type 1 diabetes are treated with insulin injections and other diabetes drugs.

- Type 2: Approximately 90-95% of diabetics are Type 2, which develops when a person does not produce enough insulin or has become resistant to the insulin they produce. While Type 2 patients can initially be treated with tablets, in the long run most patients must switch to insulin injections.[37]

221. Diabetes has been on the rise for decades. In 1958, only 1.6 million Americans had diabetes. By the turn of the century, however, that number had grown to over ten million. Fourteen years later, that number had tripled. Today, more than 38 million Americans—approximately 12% of the country—live with the disease.

222. The prevalence of diabetes in Pennsylvania has increased as well.

2. *Insulin: A Century-Old Drug*

223. Even though diabetes is the eighth leading cause of death in the United States, it is a treatable disease and has been for almost a century. Patients who follow a prescribed treatment plan consistently avoid severe health complications associated with the disease.

[37] National Institute of Diabetes and Digestive and Kidney Diseases, *What is Diabetes?* (Apr. 2023), https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes (last visited Dec. 16, 2025).

224. In 1922, Frederick Banting and Charles Best, while working at the University of Toronto, pioneered a technique for removing insulin from an animal's pancreas that could then be used to treat diabetes. Banting and Best obtained a patent and then sold their patent rights to the University of Toronto for $1 (equivalent to $18 today), reasoning that "[w]hen the details of the method of preparation are published anyone would be free to prepare the extract, but no one could secure a profitable monopoly."[38]

225. The University of Toronto contracted with Defendants Eli Lilly and Novo Nordisk to scale its production. Under this arrangement, Eli Lilly and Novo Nordisk were allowed to apply for patents on variations to the manufacturing process.

226. The earliest insulin was derived from animals and, until the 1980s, was the only treatment for diabetes. While effective, animal-derived insulin created the risk of allergic reactions. This risk was reduced in 1982 when synthetic insulin—known as human insulin because it mimics the insulin humans make—was developed by Eli Lilly. Compared to animal-derived insulin, human insulin is cheaper to mass-produce and causes fewer allergic reactions. Eli Lilly marketed this insulin as Humulin. The development of human insulin benefited heavily from government and non-profit funding through the National Institutes of Health and the American Cancer Society.

[38] Michael Bliss, The Discovery of Insulin (2013).

227. In the mid-1990s, Eli Lilly introduced the first analog insulin—a laboratory-grown and genetically altered insulin. These altered forms of human insulin are called "analogs" because they are analogous to the human body's natural pattern of insulin release and lower blood sugar more quickly. Eli Lilly released this analog in 1996 under the brand name Humalog at a cost of $21 per vial (equivalent to $40 in 2022).

228. Other rapid-acting analogs include Novo Nordisk's Novolog and Sanofi's Apidra, which have similar profiles. Rapid-acting insulins are used in combination with longer-acting insulins, such as Sanofi's Lantus and Novo Nordisk's Levemir.

229. The Manufacturer Defendants introduced these rapid-acting and long-acting analog insulins between 1996 and 2007.

230. In 2015, Sanofi introduced Toujeo, another long-acting insulin similar to Lantus. Toujeo is highly concentrated, reducing injection volume as compared to Lantus.

231. In December 2015, Eli Lilly introduced Basaglar—a long-acting insulin that is biologically similar to Sanofi's Lantus. When introduced and for years thereafter, analog insulins remained affordable; however, Defendants' Insulin Pricing Scheme has resulted in incredible price increases.

232. Even though insulin was first extracted one hundred years ago, and

despite its profitability, Eli Lilly, Novo Nordisk, and Sanofi still make nearly all of the insulin sold in the United States. This was not a chance occurrence.

233. Many of the at-issue medications are now off-patent. The Manufacturers maintain market domination through patent "evergreening." Drugs usually face generic competition when their twenty-year patents expire. While the original insulin formulas may technically be available for generic use, the Manufacturers "stack" additional patents around the original formulas, making new competition riskier and more costly. Sanofi has filed more than seventy patents on Lantus—more than 95% of which were filed after the drug was approved by the FDA—potentially providing more than three additional decades of patent "protection" for the drug. The market therefore remains concentrated.

234. In 2021, the U.S. House of Representatives Committee on Oversight and Reform issued a report following its investigation into drug pricing (the "Drug Pricing Investigation").[39] It included inquiry into the Manufacturer Defendants' insulin pricing strategies,[40] and concluded that: "Every company in the Committee's

[39] *Drug Pricing Investigation: Majority Staff Report*, Comm. on Oversight and Reform, U.S. H.R., Dec. 2021, available at https://oversightdemocrats.house.gov/sites/evo-subsites/democrats-oversight.house.gov/files/DRUG%20PRICING%20REPORT%20WITH%20APPENDIX%20v3.pdf (last visited Dec. 16, 2025) (hereinafter "*Drug Pricing Investigation*").

[40] *Id.*at 4, n.5.

investigation engaged in one or more strategies to suppress competition from generics or biosimilars, and keep prices high."[41] It also stated that:

> Insulin manufacturers have also used secondary patents to extend their market monopolies. A 2020 study by the State of Colorado found, "Many insulin products have received additional patents, exclusivities, and extensions, adding decades of protection and monopoly prices." According to this study, secondary patents enabled Eli Lilly to add 17 years of protection for Humalog, Novo Nordisk to add 27 years of protection for NovoLog, and Sanofi to add 28 years of protection for Lantus.[42]

3. *The Current Insulin Landscape*

235. Insulin today is generally safer and more convenient to use than when originally developed but questions still exist about whether the overall efficacy of insulin has significantly improved over the last twenty years.

236. For one example, while long-acting analogs may have certain advantages over human insulins (e.g., they provide greater flexibility around mealtime planning), it has yet to be shown that analogs lead to better long-term outcomes. Recent studies suggest that older human insulins may work as well as newer analog insulins for patients with Type 2 diabetes.

237. Notably, all insulins at issue in this case have either been available in the same form since the late 1990s or early 2000s or are biologically equivalent to insulins that were available then.

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[41] *Id.* at 13.

[42] *Id.* at 103.

238. As explained in the Journal of the American Medical Association by Dr. Kasia Lipska, an endocrinologist at the Yale School of Medicine and Clinical Investigator at the Yale-New Haven Hospital Center for Outcomes Research and Evaluation:

> We're not even talking about rising prices for better products here. I want to make it clear that we're talking about rising prices for the same product. . .[T]here's nothing that's changed about Humalog. It's the same insulin that's just gone up in price and now costs ten times more.[43]

239. It is also the case that production costs have decreased in recent years. A September 2018 study in BMJ Global Health calculated that, based on production costs, a reasonable and profitable price for a *one-year supply* of human insulin is between $48 and $71 per person and between $78 and $133 for analog insulin. Another recent study found that the Manufacturers could be profitable charging as little as $2 per vial.[44] A third study, based on data collected through 2023, concluded that sustainable cost-based prices "for treatment with insulin in a reusable pen device could cost as little as $96 (human insulin) or $111 (insulin analogues) *per year* for a basal-bolus regimen, $61 *per year* using twice-daily injections of mixed human insulin, and $50 (human insulin) or $72 (insulin analogues) *per year* for a once-daily

[43] Natalie Shure, *The Insulin Racket,* AMERICAN PROSPECT (June 24, 2019), https://prospect.org/health/insulin-racket/ (last visited Dec. 16, 2025).

[44] Dzintars Gotham, Melissa J. Barber & Andrew Hill, *Production Costs and Potential Prices for Biosimilars of Human Insulin and Insulin Analogues*, 3 BMJ Glob. Health e000850 (2018)

basal insulin injection (for type 2 diabetes), including the cost of injection devices and needles."[45]

240. These are not the prices paid by purchasers. In 2016, diabetics spent an average of $5,705 for insulin. According to a 2020 RAND report, the 2018 list price per vial across all forms of insulin was $14.40 in Japan, $12.00 in Canada, $11.00 in Germany, $9.08 in France, $7.52 in the United Kingdom, and less than $7.00 in Australia. In the United States, it was $98.70.[46]

241. RAND issued an updated report in 2024 using the data from 2022. In its updated report, RAND explained that the gross (or list) price of insulin in the United States had "increased dramatically since the early 2010s in the United States."[47] The report pointed to studies showing that "manufacturer gross prices increased annually by an average of 13 percent from 2007 to 2018," which was "far above general inflation over the same periods."[48]

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[45] Melissa J. Barber, PhD, Dzintars Gotham, MBBS, Helen Bygrave, MBBS & Christa Cepuch, MPH, *Estimated Sustainable Cost-Based Prices for Diabetes Medicines*, 7 JAMA Netw. Open e243474 (Mar. 27, 2024).

[46] *The Astronomical Price of Insulin Hurts American Families*, RAND (Jan. 6, 2021), https://www.rand.org/blog/rand-review/2021/01/the-astronomical-price-of-insulin-hurts-american-families.html (last visited Dec. 17, 2025).

[47] Andrew W. Mulcahy & Daniel Schwam, *Comparing Insulin Prices in the United States to Other Countries: Updated Results Using 2022 Data*, RAND Corp., RR-A788-2 (Feb. 1, 2024), at 1, https://www.rand.org/pubs/research_reports/RRA788-2.html (last visited Dec. 17, 2025).

[48] *Id.*

242. The updated RAND report also found that insulin prices in the United States far exceeded insulin prices abroad. RAND found that U.S. manufacturer gross prices were 9.71 times higher than in the thirty-three countries who belong to the Organization for Economic Co-operation and Development (OECD) combined.[49] In other words, insulin in the United States was more than nine times higher than in thirty-three middle- to high-income comparison countries.[50] Once rebates and other discounts were applied, net prices in the United States remained 2.33 times higher than in the OECD countries.[51] The gross price is the price paid by patients who are either uninsured, in the deductible phase of their plan, or otherwise paying out-of-pocket for insulin.[52]

243. While research and development costs often contribute significantly to a drug price, the initial basic insulin research—original drug discovery and patient trials—occurred decades ago and those costs have long since been recouped. And even recent costs, such as developing the recombinant DNA fermentation process and the creation of insulin analogs, were incurred decades ago. In recent years, the bulk of R&D costs is incurred in connection with the development of new insulin-

[49] *Id.* at v, 22, 30.

[50] *Id.*

[51] *Id.* at v, 28, 30.

[52] *Id.* at vi.

related devices and equipment, not in connection with the drug formulations themselves.

244. The House Committee on Oversight and Reform in the Drug Pricing Investigation also found that R&D costs "d[id] not justify price increases."[53] According to the committee, "when drug companies did invest in R&D, those expenditures often went to research designed to protect existing market monopolies." [54] The committee also found that "drug companies often invested in development only after other research—much of it federally funded—demonstrated a high likelihood of financial success."[55]

245. In response to rising scrutiny, the Manufacturer Defendants announced limited pricing changes and out-of-pocket limits. On March 1, 2023, Eli Lilly announced that it would cap the prices of certain insulin medications at $35 per month, with additional reductions to follow later in the year. Specifically, Eli Lilly promised that it would list its Lispro injection at $25 per vial effective May 1, 2023, and cut the price of its Humalog and Humulin injections by 70% starting in the fourth quarter of 2023. The price reductions to date are limited to these medications and do not apply to other Eli Lilly diabetes medications such as Trulicity and Basaglar.

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[53] *Drug Pricing Investigation*, *supra* note 39, at xv.

[54] *Id.* at 164.

[55] *Id.*

These decisions suggest that, prior to March 1, 2023, the prices of these medications had not been raised to cover costs of research and development, manufacture, distribution, or any other necessary expense.

246. On March 14, 2023, two weeks after Eli Lilly announced that it would be implementing pricing changes, Novo Nordisk followed with an announcement that it would also lower the U.S. list prices of several insulin products by up to 75%—specifically, Levemir, Novolin, NovoLog, and NovoLog Mix 70/30. "The price reductions to date are limited to these medications and do not apply to other Novo Nordisk diabetes medications like Victoza and Ozempic." These changes went into effect on January 1, 2024, and, as with Eli Lilly's price reduction, suggest that the prices of these medications before that date were not increased to cover costs of research and development, manufacture, distribution, or any other necessary expense.

247. These three announcements (the "Price Cuts") were prospective and do not mitigate damages already incurred by payors like Plaintiffs before the time of the Price Cuts.

248. The Price Cuts are limited to certain insulin medications, and do not encompass all at-issue medications. As part of the Insulin Pricing Scheme, PBMs provide preferred formulary placement to the expensive insulins based on list prices. Accordingly, the Insulin Pricing Scheme continues, with the PBMs continuing to target the most expensive at-issue medications—likely those not included in the Price

Cuts.

249. The Price Cuts are woefully insufficient. An Eli Lilly spokeswoman has represented that the current list price for a ten-milliliter vial of the fast-acting, mealtime insulin Humalog will drop to $66.40 from $274.70, and a ten-milliliter vial of Humulin will fall from $148.70 to $44.61.[56] These prices far exceed the Manufacturer Defendants' costs and remain significantly higher than prices for the same and similar drugs in other countries.

250. Even worse, on November 8, 2023, before the 65% price cut for its long-acting insulin Levemir had taken effect, Novo Nordisk announced that it would be *discontinuing* Levemir in the United States, citing manufacturing constraints, formulary-placement issues, and "alternative treatments" for patients. Levemir is the *only* branded, long-acting insulin product for which Novo Nordisk announced a list price reduction and the *only* long-acting insulin FDA-approved for pregnancy. However, Novo Nordisk discontinued Levemir before allowing the price reduction to take effect, with supply disruptions beginning in early 2024, followed by formal discontinuation of the Levemir FlexPen vial by the end of 2024.

[56] Tom Murphy, *Lilly Plans to Slash Some Insulin Prices, Expand Cost Cap*, AP News (Mar. 2, 2023), https://apnews.com/article/insulin-diabetes-humalog-humulin-prescription-drugs-eli-lilly-lantus-419db92bfe554894bdc9c7463f2f3183 (last visited Dec. 17, 2025).

4. *Insulin Adjuncts: Type 2 Medications*

251. Over the past fifteen years, the Manufacturer Defendants have released several non-insulin medications that help control insulin levels. In 2010, Novo Nordisk released Victoza, and thereafter Eli Lilly released Trulicity while Sanofi released Soliqua. Novo Nordisk further expanded their GLP-1 patent portfolio with the approval of Xultophy and Ozempic.[57] In 2022, Eli Lilly received approval for another GLP-1, Mounjaro. Each of these medications can be used in conjunction with insulins to control diabetes.

252. The Manufacturers negotiate rebates and other fees with the PBMs for "bundles" of insulin and GLP-1 receptor agonist (GLP-1) medications, packaging them as a single class of diabetes medications. This practice is known as "bundling."

253. The Manufacturer Defendants bundle medications to gain formulary access for multiple drugs in exchange for higher manufacturer payments to the PBMs.

254. In 2013, Novo Nordisk tied its "exclusive" rebates for insulin to formulary access for GLP-1 medication, Victoza. The exclusive rebates of 57.5% for Novolin, Novolog, and Novolog Mix 70/30 were more than three times higher than the 18% rebate for plans that included two insulin products on their formulary.

[57] Victoza, Trulicity, Ozempic, and Mounjaro are glucagon-like peptide-1 receptor agonists ("GLP-1") and mimic the GLP-1 hormone produced in the body. Soliqua and Xultophy are combination long-acting insulin and GLP-1 drugs.

In order to qualify for the exclusive rebate, the plans would also need to list Victoza on their formulary, exclude all competing insulin products, and ensure existing patients switch from competitor diabetes medications.[58]

255. Upon information and belief, each of the Manufacturer Defendants negotiate the prices of insulin and GLP-1 medications through bundling.

256. The first GLP-1 was approved by the FDA in 2005 and was indicated for the treatment of Type 2 diabetes. Currently, the GLP-1 market is consolidated among a limited number of patent-holding entities, with Manufacturer Defendants Eli Lilly, Novo Nordisk, and Sanofi controlling much of this market.

257. Through extensive patents and regulatory exclusivities, the Manufacturer Defendants have effectively stopped competition in the GLP-1 market, giving them the ability to exercise control over the price of GLP-1 medications.

258. No generic alternative exists for any GLP-1 medication. The Manufacturer Defendants will continue to enjoy patent protection of their respective GLP-1 agonist molecules through at least 2030.[59]

[58] Senate Insulin Report at *supra* note 7, at 71.

[59] Rasha Alhiary, *et al.*, *Patents and Regulatory Exclusivities on GLP-1 Receptor Agonists*, J. OF THE AM. MED. ASS'N, Vol. 330, at 650-57 (2023).

259. Novo Nordisk developed and sells three GLP-1 drugs indicated for Type 2 diabetes: Victoza (liraglutide), Xultophy (insulin degludec/liraglutide), and Ozempic (semaglutide). Novo Nordisk holds sixty-two patents related to semaglutide and liragutide, forty-six of which are device patents that are not related to the therapeutic molecule of the GLP-1.[60]

260. Eli Lilly developed and sells two GLP-1 drugs indicated for Type 2 diabetes: Trulicity (dulaglutide) and Mounjaro (tirzepatide/GIP). Eli Lilly holds eighteen patents related to dulaglutide and tirzepatide. Of the four patents related to tirzepatide, two are device patents unrelated to the therapeutic molecule of the GLP-1.

261. Sanofi developed Adylxin (lixisenatide) and Soliqua (insulin glargine/lixisenatide) but currently only sells Soliqua in the United States. Sanofi holds forty-two patents related to lixisenatide, twenty-nine of which are device patents unrelated to the therapeutic molecule of the GLP-1.[61]

262. Manufacturer Defendants' actions in patent stacking and evergreening ensures that generic and other branded GLP-1 cannot enter the market and gives them disproportionate pricing power over GLP-1 medications.

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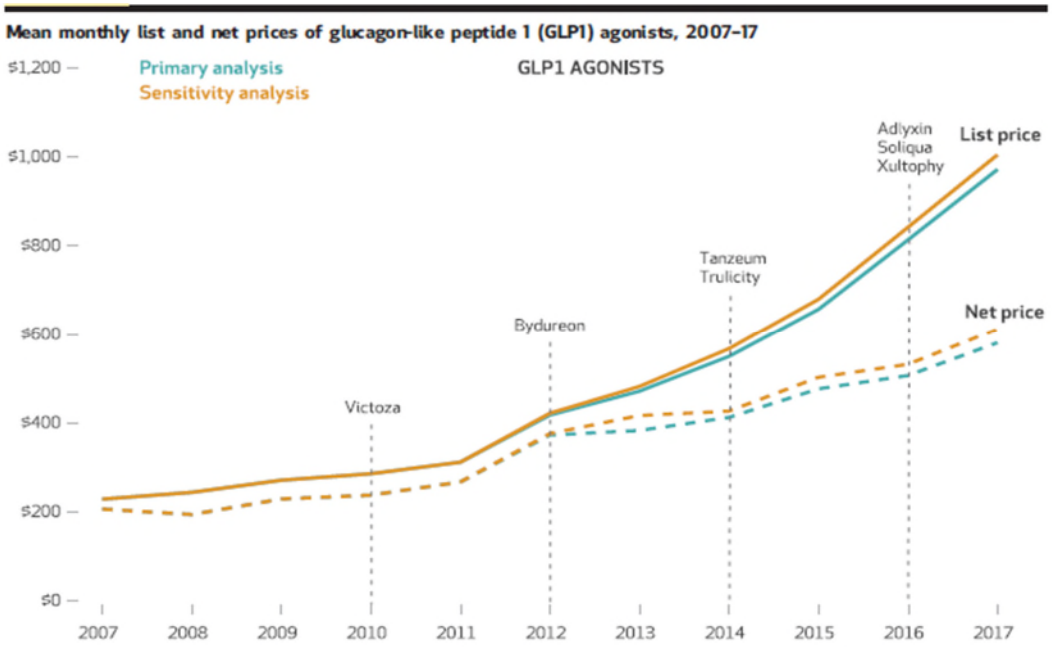
[60] Rasha Alhiary, *et al.*, *Delivery Device Patents on GLP-1 Receptor Agonists*, J. OF THE AM. MED. ASS'N, Vol. 331, at 794-796 (2024).

[61] *Id.*

263. In addition to the limited competition for GLP-1 drugs, the Manufacturer and PBM Defendants use the disproportionate pricing power to inflate the prices of GLP-1s, consistent with the Insulin Pricing Scheme.

Figure 3: List and net prices of GLP-1 agonists



264. The above graph shows that list and net prices increased as more GLP-1 medications were approved and introduced. Between 2007 and 2017, the average list price of GLP-1s rose 15% per year despite the introduction of competing brands. The net price increased an average of 10% per year during the same time period.[62]

[62] Ameet Sarpatwari, et al., Diabetes Drugs: List Price Increases Were Not Always Reflected In Net Price; Impact Of Brand Competition Unclear, HEALTH AFFAIRS, Vol. 40, at 772-78 (2021).

265. The PBM Defendants are also integral to these price increases. As shown in the chart above, the growing disconnect between the list and net prices of these drugs further reflects the PBM Defendants' profits through identical methods to those employed in the Insulin Pricing Scheme.

266. The absence of generics in the GLP-1 market allows manufacturers to keep prices artificially high. PBMs then realize the benefit of these artificially high prices through manufacturer payments in exchange for formulary placement. PBMs and manufacturers are thus incentivized to increase prices or maintain high prices for GLP-1s.

267. GLP-1s are much more expensive in the United States than in other countries, indicating that the increasing price of GLP-1s are not linked to any legal, competitive, or fair market price. For example, in 2023, the list price for a one-month supply of Ozempic was about $936 in the United States, $147 in Canada, $103 in Germany, $93 in the United Kingdom, $87 in Australia, and $83 in France.

268. In 2018, Victoza's list price in the United States was more than double its average list price in eleven comparable countries. Trulicity's list price in the United States was more than six times its average list price in eleven comparable countries. However, at least one study found that drug companies could profitably sell certain GLP-1s, including Ozempic, for $0.89-$4.73 per month.

269. In March 2024, PBM Defendant Evernorth entered into a guarantee agreement for GLP-1 spend with Manufacturer Defendants Novo Nordisk and Eli Lilly to limit the annual cost increase of GLP-1s to 15%.[63]

270. Like the caps put in place for insulins, Evernorth, Eli Lilly, and Novo Nordisk's guarantee agreements suggests that the prices of GLP-1s before March 2024 were not raised to cover costs of research and development, manufacture, distribution, or any other necessary expense, but instead indicate that the increasing price of GLP-1s were untethered to any legal, competitive, or fair market price. Further, this agreement is prospective and does not mitigate damages already incurred by payors like Plaintiffs.

271. The following is a table of diabetes medications at issue in this lawsuit:

Insulin Type	Action	Name	Mfr.	FDA Appr.	Current/Recent List Price
Human	*Rapid-Acting*	Humulin R	Eli Lilly	1982	$178 (vial)
		Humulin R 500	Eli Lilly	1982	$1784 (vial) $689 (pens)
		Novolin R	Novo Nordisk	1991	$165 (vial) $312 (pens)
	Intermediate	Humulin N	Eli Lilly	1982	$178 (vial) $566 (pens)
		Humulin 70/30	Eli Lilly	1989	$178 (vial) $566 (pens)
		Novolin N	Novo Nordisk	1991	$165 (vial) $312 (pens)
		Novolin 70/30	Novo Nordisk	1991	$165 (vial) $312 (pens)
Analog	*Rapid-Acting*	Humalog	Eli Lilly	1996	$342 (vial) $636 (pens)

[63] Evernorth Health Services, *Evernorth Announces Industry-First Financial Guarantee on GLP-1 Spend*, Evernorth (Mar. 7, 2024), available at https://www.evernorth.com/articles/evernorth-announces-industry-first-financial-guarantee-glp-1-spend (last visited Dec. 17, 2025).

Insulin Type	Action	Name	Mfr.	FDA Appr.	Current/Recent List Price
		Novolog	Novo Nordisk	2000	$347 (vial) $671 (pens)
		Apidra	Sanofi	2004	$341 (vial) $658 (pens)
	Pre-mixed	Humalog 50/50	Eli Lilly	1999	$93 (vial) $180 (pens)
		Humalog 75/25	Eli Lilly	1999	$99 (vial) $140 (pens)
		Novolog 70/30	Novo Nordisk	2001	$203 (vial) $246 (pens)
	Long-Acting	Lantus	Sanofi	2000	$340 (vial) $510 (pens)
		Levemir	Novo Nordisk	2005	$370 (vial) $555 (pens)
		Basaglar (Kwikpen)	Eli Lilly	2015	$392 (pens)
		Toujeo (Solostar)	Sanofi	2015	$466 (pens) $622 (max pens)
		Tresiba	Novo Nordisk	2015	$407 (vial) $610 (pens – 100u) $732 (pens – 200u)
Type 2 Medications	*GLP-1*	Trulicity (Dulaglutide)	Eli Lilly	2014	$1013 (pens)
		Mounjaro (Tirzepatide/GIP)	Eli Lilly	2022	$1068 (pens)
		Victoza (Liraglutide)	Novo Nordisk	2010	$813 (2 pens) $1220 (3 pens)
		Xultophy (insulin degludec/liraglutide)	Novo Nordisk	2016	$1295 (pens)
		Ozempic (Semaglutide)	Novo Nordisk	2017	$1022 (pens)
		Rybelsus (semaglutide tablets)	Novo Nordisk	2019	$1029 (30 day supply)
		Adylxin (lixisenatide)	Sanofi	2016	Discontinued 2023
		Soliqua (insulin glargine/lixisenatide)	Sanofi	2016	$928 (pens)

B. The Dramatic Rise in U.S. Prices for Diabetes Medications

272. Over the past twenty-five years, the list price of certain insulins has increased by more than 1000% (10x). By comparison, $165 worth of consumer goods and services in 1997 dollars would, in 2021, have cost $289 (1.75x).[64]

[64] The Consumer Price Index (CPI) measures "the average change over time in the prices paid by urban consumers for a market basket of consumer goods and

273. Since 1997, Eli Lilly has raised the list price of a vial of Humulin R (500U/mL) from $165 to $1784 in 2021 (10.8x).

274. Since 1996, Eli Lilly has raised the price for a package of Humalog pens from less than $100 to $663 (6.6x) and from less than $50 per vial to $342 (6.8x).

275. From 2006 to 2020, Novo Nordisk has raised Levemir's list price from $162 to $555 (3.4x) for pens and from under $100 to $370 per vial (3.7x).

276. From 2002 to 2021, Novo Nordisk raised Novolog's list price from $108 to $671 (6.2x) for a package of pens and from less than $50 to $347 (6.9x) per vial.

277. Defendant Sanofi has also raised prices. It manufactures a top-selling analog insulin—Lantus—which has been and remains a flagship brand for Sanofi. Lantus has been widely prescribed nationally and within Pennsylvania, including to Plaintiffs' Beneficiaries. Sanofi has raised the list prices for Lantus from less than $200 in 2006 to more than $500 in 2020 (2.5x) for a package of pens and from less than $50 to $340 per vial (6.8x).

278. The Manufacturer Defendants have similarly increased the prices for non-insulin diabetes medications.

279. Driven by these price hikes, payors' and diabetics' spending on these drugs has steadily increased with totals in the tens of billions of dollars.

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services." https://www.bls.gov/data/inflation_calculator.htm (last visited Dec. 17, 2025).

280. The timing of the price increases reveals that the Manufacturers have not only dramatically increased prices for the at-issue treatments, but have also done so in lockstep.

281. Between 2009 and 2015, Sanofi and Novo Nordisk raised the list prices of their insulins at the same time thirteen times, making the same price increase within days and sometimes hours of each other.[65]

282. This practice, through which competitors communicate their intention not to price-compete against one another, is known as "shadow pricing."

283. In 2016, Novo Nordisk and Sanofi's lockstep increases for the at-issue drugs represented some of the highest drug price increases in the pharmaceutical industry.

284. Eli Lilly and Novo Nordisk have engaged in the same lockstep behavior with respect to their rapid-acting analog insulins, Humalog and Novolog. Figure 4 demonstrates this collusive behavior with respect to Lantus and Levemir. Figure 5 demonstrates this behavior with respect to Novolog and Humalog.

[65] Senate Insulin Report at *supra* note 29, at 47-48.

Figure 4: Rising list prices of long-acting insulins

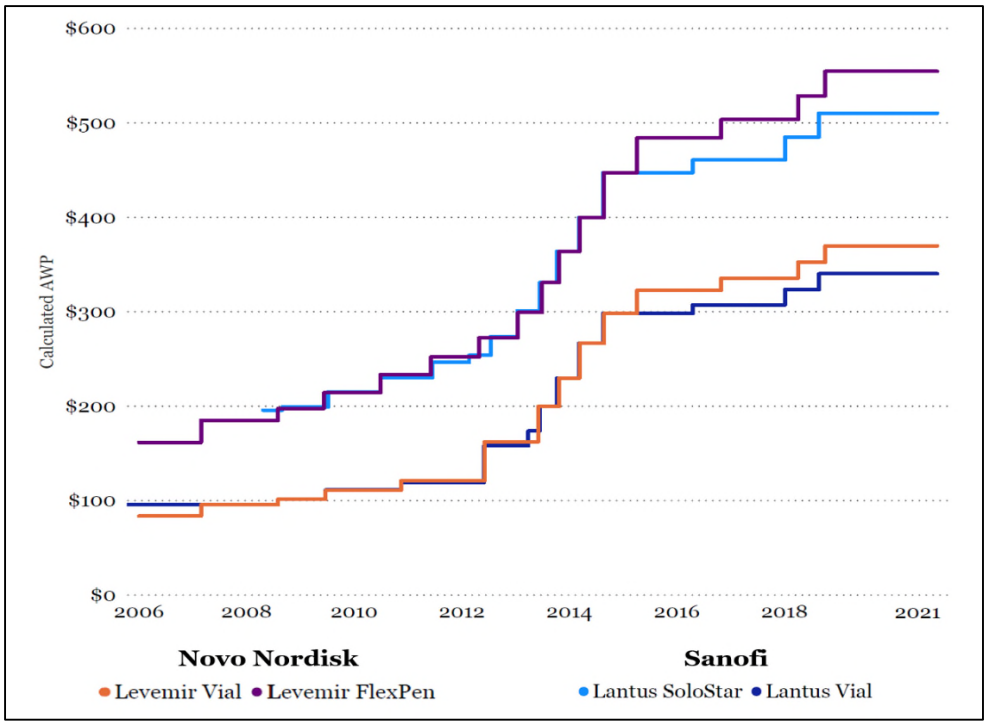
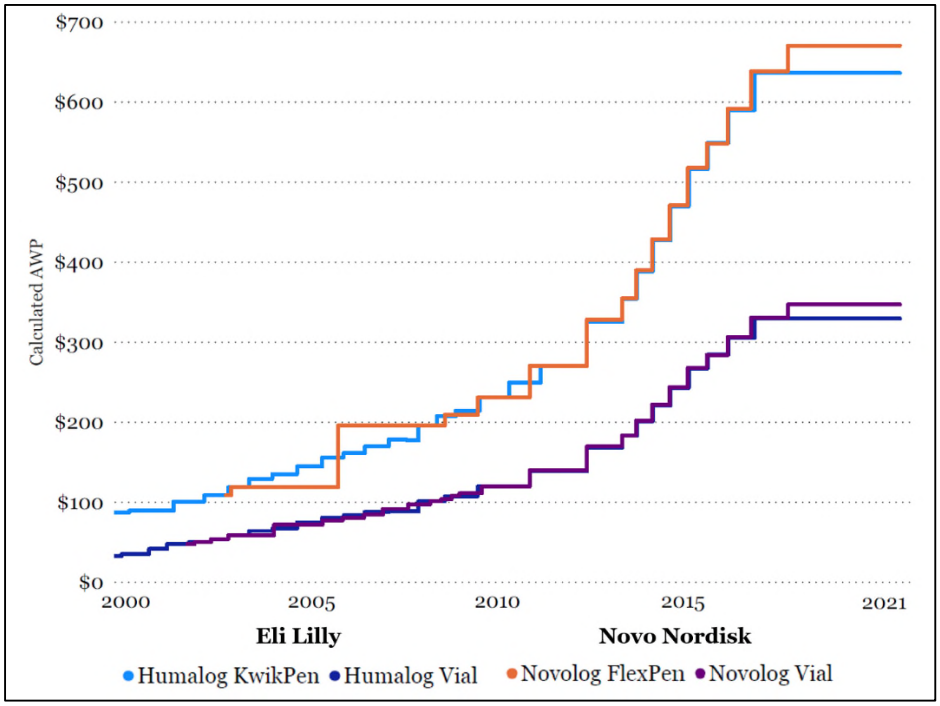


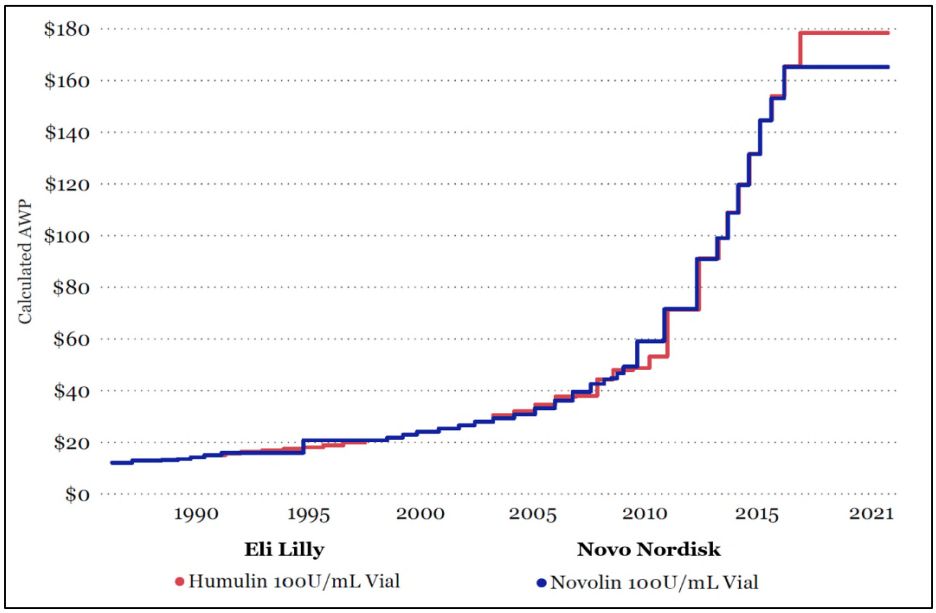
Figure 5: Rising list prices of rapid-acting insulins



285. Figure 6 demonstrates this behavior with respect to the human insulins—

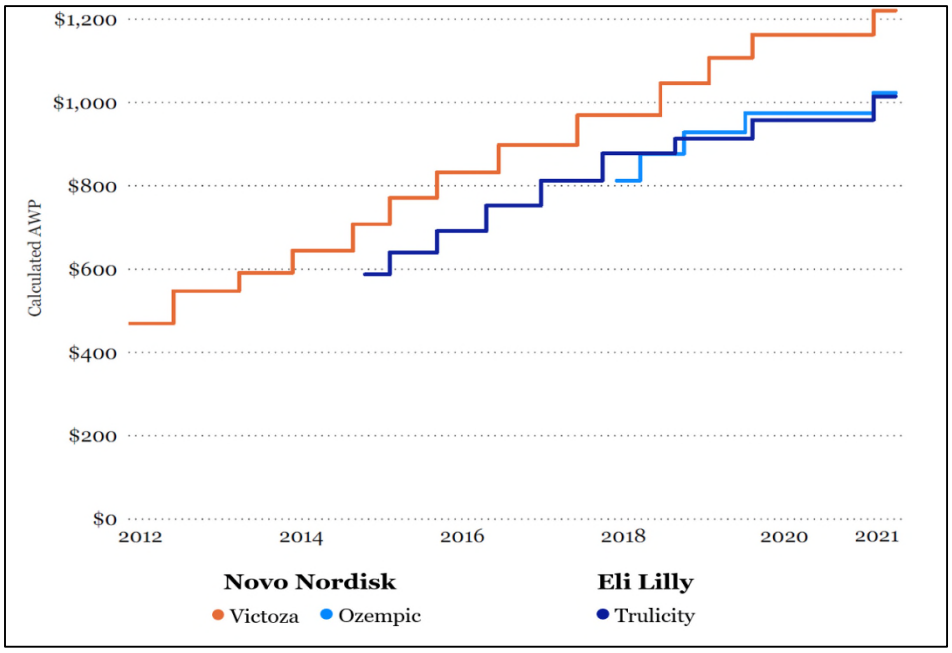
Eli Lilly's Humulin and Novo Nordisk's Novolin.

Figure 6: Rising list price increases for human insulins



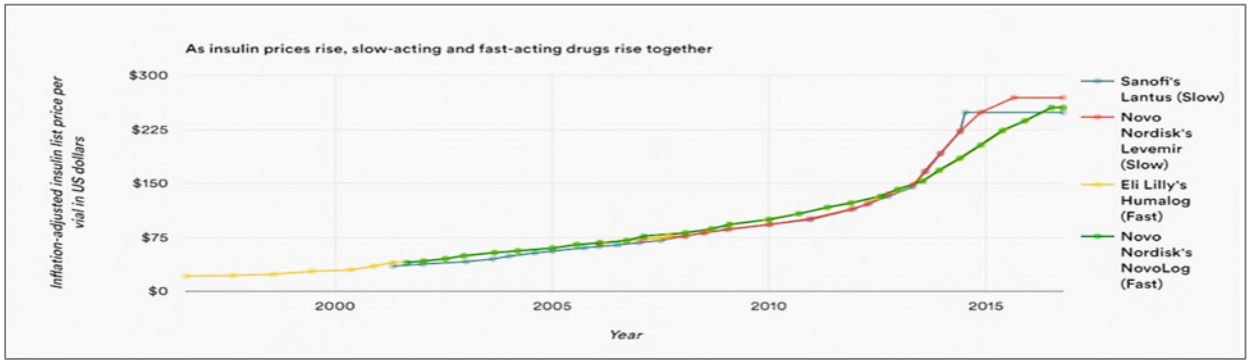
286. Figure 7 below demonstrates Novo Nordisk and Eli Lilly's lockstep price increases for their Type-2 drugs Trulicity, Victoza, and Ozempic.

Figure 7: Rising list prices of Type 2 drugs

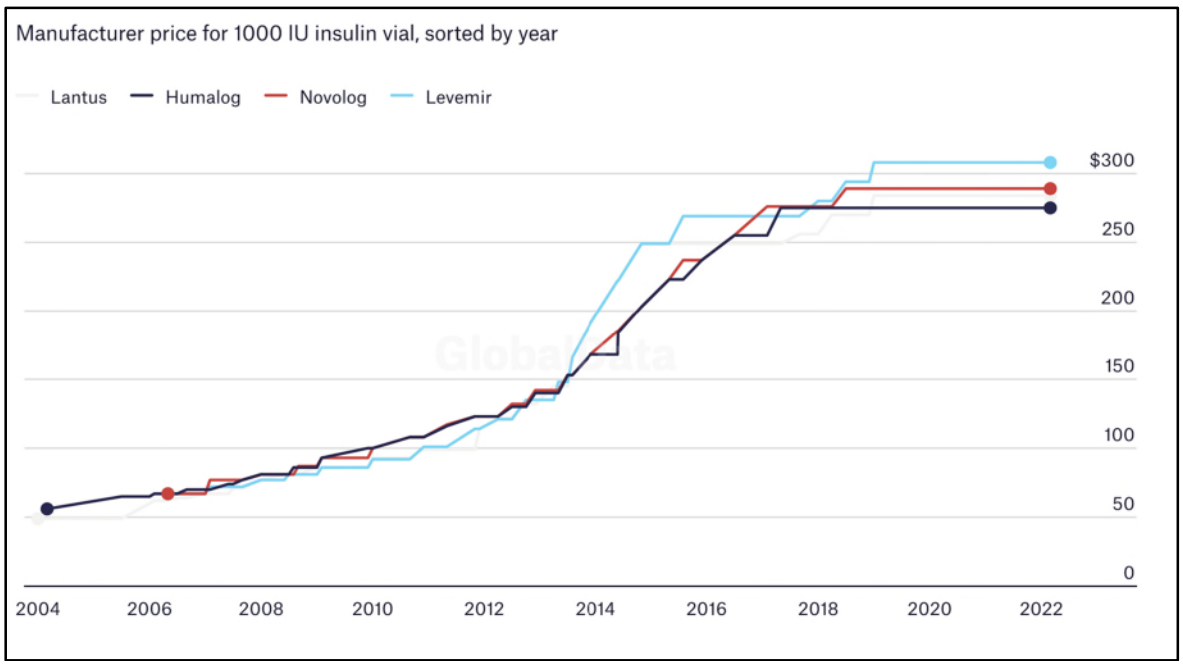


287. Figures 8 and 9 below show how the Manufacturers have raised the prices of insulin products in unison.[66]

Figures 8 and 9: Lockstep insulin price increases



[66] William Newton, *Insulin Pricing: Could an E-Commerce Approach Cut Costs?*, Pharmaceutical Technology (Mar. 31, 2022), https://www.pharmaceutical-technology.com/features/insulin-pricing-could-an-e-commerce-approach-cut-costs/ (last visited Dec. 17, 2025).



288. These lockstep price increases were coordinated to preserve formulary placement for the at-issue medications and to allow greater rebates to the PBMs, and further illustrate the economics of competing by increasing prices in lockstep.

289. Eli Lilly was not inclined to lower prices of its insulin products to compete with the other drug makers. Documents produced to the House Committee on Oversight and Reform[67] show that Eli Lilly regularly monitored competitors' pricing activity and viewed competitors' price increases as justification to raise the prices of their own products. On May 30, 2014, a senior vice president at Eli Lilly sent a proposal to Enrique Conterno—then-President of Lilly Diabetes—for June 2014 price increases for Humalog and Humulin. The executive reported that Novo

[67] Drug Pricing Investigation at *supra* note 39, at 162.

Nordisk had just executed a 9.9% price increase across its insulin portfolio. Mr. Conterno remarked, "While the list price increase is higher than we had planned, I believe it makes sense from a competitive perspective."[68] Eli Lilly took a 9.9% price increase shortly thereafter, on June 5, 2014.

290. Six months later, on November 19, 2014, Mr. Conterno reported to then-CEO John Lechleiter that Novo Nordisk had taken another 9.9% price increase on NovoLog—the direct competitor to Eli Lilly's Humalog. Mr. Conterno wrote, "[a]s you are aware, we have assumed as part of our business plan a price increase of 9.9% for Humalog before the end of the year."[69] The following Monday—six days after Mr. Conterno's initial email to the CEO—Eli Lilly took price increases of 9.9% on all Humalog and Humulin products.

291. Sanofi also closely monitored competitors' pricing activity and planned its own pricing decisions around Eli Lilly's and Novo Nordisk's price increases. Executives were aware that Sanofi's long-acting insulin competitors—particularly Novo Nordisk—would likely match its pricing actions on long-acting insulin. Internal documents show that Sanofi leaders welcomed competitors' price increases because they allowed Sanofi to claim it was maintaining pricing "parity" with competitors.

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[68] *Id.*

[69] *Id.* at 140.

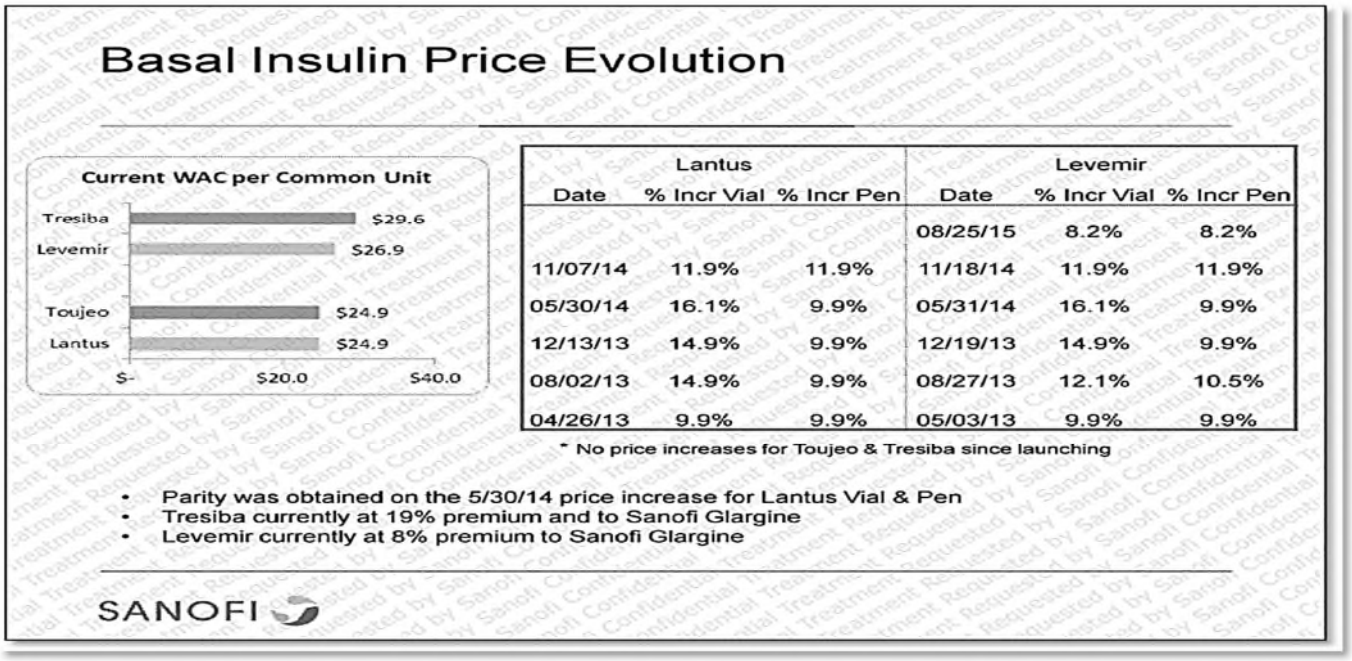
292. Sanofi had no incentive or intention to lower its insulin pricing. For example, on November 7, 2014, Sanofi executed a price increase of approximately 12% across its family of Lantus products. The following week, a Sanofi senior vice president sent an email asking, "[d]id Novo increase the price of Levemir following our price increase on Lantus last week? I just want to confirm we can still say that Lantus and Levemir are still priced at parity on a WAC [wholesale acquisition cost] basis."[70] The head of Sanofi pricing responded that Novo Nordisk had not yet taken the price increase, but noted, "[o]ver the past four price increases on Lantus they have typically followed within 1 month."[71] Novo Nordisk raised the price of Levemir by 12% the following week.

293. An internal Sanofi chart shows that, between April 2013 and November 2014, each time Sanofi raised the price of Lantus, Novo Nordisk followed suit for Levemir:

[70] *Id.*

[71] *Id.* at 141.

Figure 10: Sanofi price-tracking



294. The Manufacturers used their competitors' price increases as justification for their own increases. For example, before taking price increases on Lantus, Sanofi compared the new list price to the prices of competitor products. In an April 2018 email exchange about accelerating and increasing previously planned price increases for Lantus and Toujeo (from July to April, and from 3% on Lantus to 5.3%), one senior director requested, "[p]lease confirm how the new WAC of Lantus/Toujeo would compare with the WAC of Levemir/Tresiba."[72] In reply, another senior Sanofi leader provided a chart comparing Sanofi prices to those of its competition.

[72] *Id.* at 141.

295. Sanofi also engaged in shadow pricing with its rapid-acting insulin products, including Apidra. Sanofi was not the market leader in the fast-acting insulin space and typically did not act first to raise prices. But, Sanofi quickly followed competitor price increases. As a Sanofi marketing document explained: "Over the past three years, we have executed a 'fast follower' strategy for Apidra and have executed price increases only after a price increase was announced."[73]

296. In December 2018, Sanofi's director of strategic pricing and planning emailed diabetes and cardiovascular pricing committee members seeking approval for across-the-board price *increases* for its rapid- and long-acting insulin products, including Lantus, Toujeo, and Apidra. The then-Senior Vice President and Head of Sanofi's North America General Medicines group forwarded the proposal to the then-Senior Vice President and Head of Sanofi's External Affairs and inquired, "[p]rior to my approval, just confirming that we are still on for these."[74] The Head of Sanofi's External Affairs wrote back, "Yes. As of now I don't see any alternative. Not taking an increase won't solve the broader policy/political issues, and based on intel, believe many other manufacturers plan to take increases next year as well."[75] He added, "[s]o while doing it comes with high political risk, I don't see any political upside to not

[73] *Id.* at 142.

[74] *Id.*

[75] *Id.*

doing it."[76]

297. Although Sanofi generally led price increases in the long-acting insulin market with Lantus pricing, Novo Nordisk often led in the rapid-acting market with NovoLog. On May 8, 2017, Novo Nordisk CEO Lars Jorgenson learned that Eli Lilly had raised U.S. list prices by approximately 8% across its injectable diabetes drug portfolio. Mr. Jorgenson emailed this information to a Novo Nordisk executive and asked, "[w]hat is our price increase strategy?"[77] The executive responded, "[Eli Lilly] followed our increase on NovoLog, so we're at parity here, so no action from us. They led with Trulicity and based on our strategy, we will follow which will likely be on June or July 1st."[78]

298. Further illustrating the anticompetitive scheme between the Manufacturers, rather than compete by lowering prices, Sanofi raised Lantus's list price to respond to rebate and discount competition from Novo Nordisk. Novo Nordisk manufactures two long-acting insulins called Levemir and Tresiba, as well as two rapid-acting insulins, NovoLog and Fiasp. In the long-acting insulin category, Sanofi's Lantus and Novo Nordisk's Levemir often compete to win the same accounts. According to internal documents, in 2013, Sanofi believed that Novo

[76] *Id.*

[77] *Id.*

[78] *Id.*

Nordisk was attempting to minimize the clinical difference between Lantus and Levemir and was offering "increased rebates and/or portfolio offers for the sole purpose of removing Lantus from favorable formulary access." According to an internal Sanofi memo, "the strategy to close the price differential between the Lantus vial and pen before the LOE [loss of exclusivity] period was believed to be critical to the overall long-term success of the franchise."[79]

299. At the time, Sanofi faced increased pressure from its payor and PBM clients to offer more generous rebates and price protection terms or face exclusion from formularies. This market environment created an enormous challenge for Lantus and, in order to protect its flagship diabetes franchise, Sanofi increased Lantus's list price so that it could improve its rebate and discount offering to payors while maintaining net sales.

300. Sanofi understood the risk of its decision and "went into 2013 with eyes wide open that the significant price increases planned would inflame [its] customers," and that its aggressive pricing would cause a quick reaction from Novo Nordisk.[80] But Sanofi sought to make up for "shortfalls with Lantus demand generation and global profit shortfalls," which it said "put pressure on the US to continue with the

[79] Senate Insulin Report *supra* note 7, at 45.

[80] *Id.*

price increases to cover gaps."[81] The company conceded that it was "difficult to determine whether we would face these risks anyway if we hadn't taken the price increases."

301. Novo Nordisk engaged in similar pricing conduct with its long-acting insulin, Levemir, by increasing Levemir's list price in lockstep with Lantus in an effort to offer increased rebates and discounts to payors and displace Lantus from preferred formulary placement. Novo Nordisk typically did not act first to raise prices. However, when its competitors raised prices, Novo Nordisk followed. A March 2015 Novo Nordisk pricing committee presentation slide articulated this strategy: "Levemir price strategy is to follow market leader."[82]

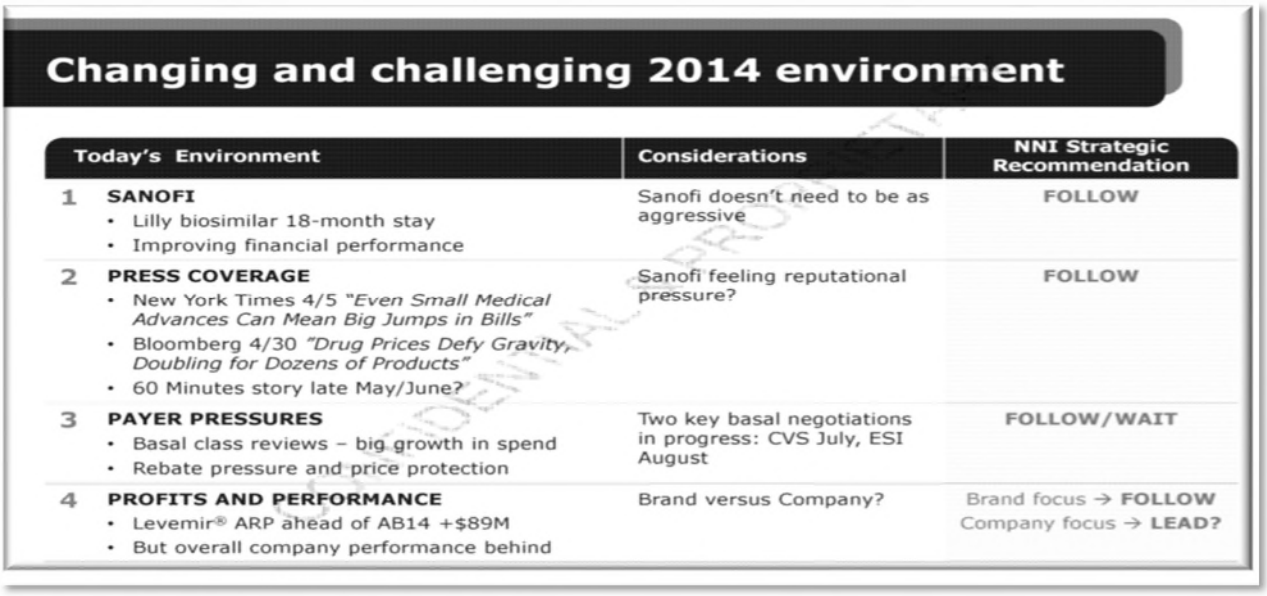
302. On May 19, 2014, Novo Nordisk's pricing committee discussed how to price Levemir in response to Sanofi's 2013 pricing actions. Based on an internal presentation reviewed at this meeting, Novo Nordisk's pricing committee discussed whether it should be a follower in relation to Sanofi, and considered external factors like press coverage, payor reactions, *profits*, and performance. In each case, the company's recommendation was to follow Sanofi's moves, rather than lead. Of note, the presentation shows that the pricing committee considered Levemir's performance, which was ahead of 2014's annual budgeting by $89 million, but that

[81] *Id.*

[82] Drug Pricing Investigation at *supra* note 39, at 143.

"overall company performance [was] behind."[83] The presentation recommends following Sanofi's pricing actions if the brand's performance is the priority, and to lead if the company's performance is the priority. An excerpt of Novo Nordisk's presentation is shown below:

Figure 11: Novo Nordisk pricing committee presentation



Changing and challenging 2014 environment

	Today's Environment	Considerations	NNI Strategic Recommendation
1	**SANOFI** • Lilly biosimilar 18-month stay • Improving financial performance	Sanofi doesn't need to be as aggressive	FOLLOW
2	**PRESS COVERAGE** • New York Times 4/5 *"Even Small Medical Advances Can Mean Big Jumps in Bills"* • Bloomberg 4/30 *"Drug Prices Defy Gravity, Doubling for Dozens of Products"* • 60 Minutes story late May/June?	Sanofi feeling reputational pressure?	FOLLOW
3	**PAYER PRESSURES** • Basal class reviews – big growth in spend • Rebate pressure and price protection	Two key basal negotiations in progress: CVS July, ESI August	FOLLOW/WAIT
4	**PROFITS AND PERFORMANCE** • Levemir® ARP ahead of AB14 +$89M • But overall company performance behind	Brand versus Company?	Brand focus → **FOLLOW** Company focus → **LEAD?**

303. In alignment with this strategy, Novo Nordisk's pricing committee debated potential pricing scenarios based on Sanofi's actions, which they projected with a great deal of specificity. The presentation provided options regarding whether the company should follow Sanofi—and increase list price in July—or lead with a 9.9% increase in August which it considered "optically less aggressive."[84] Based on

[83] Senate Insulin Report *supra* note 7, at 47.

[84] *Id.*

internal memoranda, Novo Nordisk's pricing committee decided to revisit the issue with specific recommendations once Sanofi acted.

304. On May 30, 2014, a few days later, Farruq Jafery, Vice President of Pricing, Contract Operations and Reimbursement, emailed Novo Nordisk's pricing committee to inform them that "Sanofi took a price increase on Lantus effective today: 16.1% vial and 9.9% pen."[85] He wrote that the pricing committee had "agreed that the best strategy for Levemir is to observe the market and maintain list price parity to competitors."[86] Mr. Jafery then requested that Novo Nordisk's committee vote "ASAP" to raise the list price of Levemir effective May 31, 2014 (the next day) from $191.28 to $222.08 for vials and from $303.12 to $333.12 for pens.[87] Only a few hours after Sanofi took its list price increase, members of the pricing committee approved Mr. Jafery's request and Novo Nordisk enacted a 16.1% increase on Levemir vial, and a 9.9% increase on Levemir FlexPen and FlexTouch.

305. Another series of emails shows that Novo Nordisk again shadowed Sanofi's price increase in November 2014, increasing Levemir's list price immediately after Sanofi increased Lantus vials and pens by 11.9%. On the morning of November 7, 2014, Novo Nordisk's pricing committee learned that Sanofi

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[85] *Id.*

[86] *Id.*

[87] *Id.*

increased Lantus's list price overnight. And, the same exact price increase for Levemir was approved hours later.

306. Within minutes of learning of Sanofi's price increase, Rich DeNunzio, Senior Director of Novo Nordisk's Strategic Pricing, emailed Novo Nordisk's pricing committee to alert them of the change and promise a recommendation the same afternoon after reviewing the financial impact of any move. By late afternoon, Mr. DeNunzio had requested Novo Nordisk's pricing committee to again "follow [Sanofi's] 11.9% [list price increase] on November 18th" and vote to increase Levemir's list price, which was approved by Novo Nordisk's Chief Financial Officer for U.S. operations, Lars Green.[88]

307. Novo Nordisk officials were closely monitoring Sanofi's actions as set forth in a January 27, 2014, presentation regarding the company's bidding strategy that hinged on CVS Caremark's business. Novo Nordisk described its bids for the CVS Caremark business as "pivotal," and laid out a game of cat-and-mouse across different accounts in which company officials sought to have Levemir be the only therapeutic option on different PBM formularies. Novo Nordisk recognized that offering "attractive exclusive rebates to large, receptive customers" would "encourage a stronger response from Sanofi."[89] However, Novo Nordisk was willing

[88] *Id.* at 50.

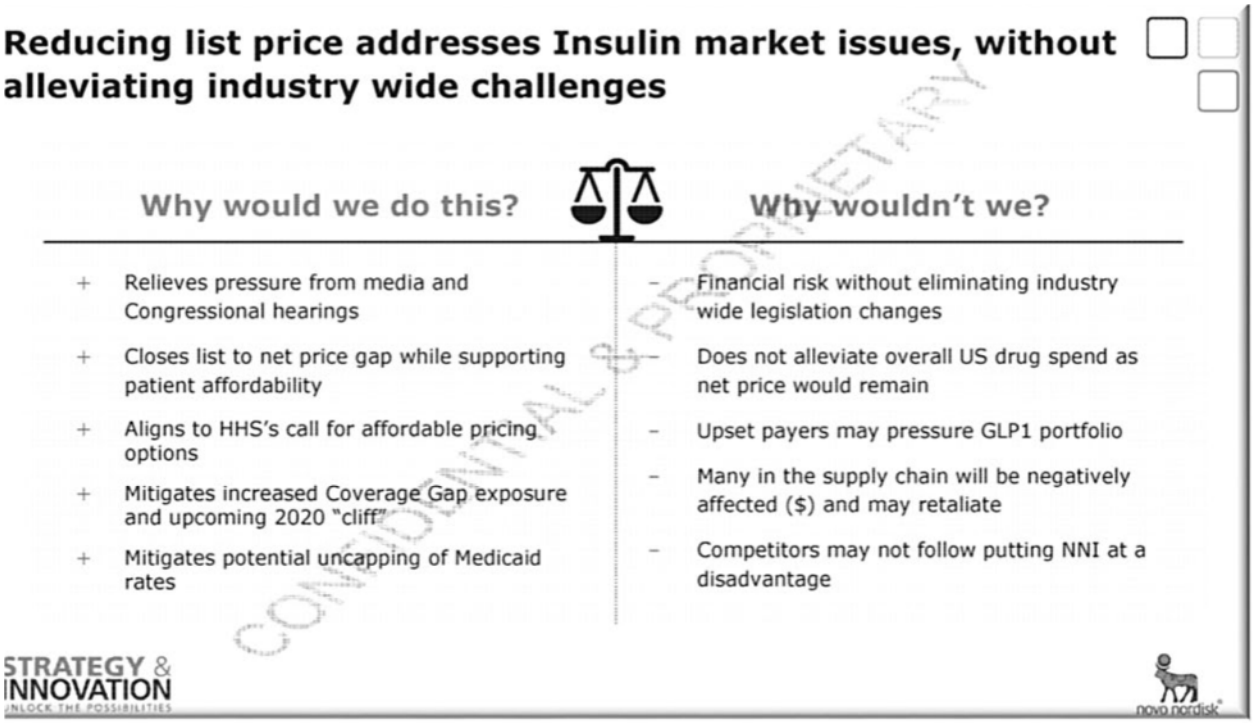
[89] *Id.* at 49.

to take this risk because it would result in "immediate volume and value" for the company and could lead to an exclusive deal for CVS's commercial formulary.[90]

308. The agreements the Manufacturers had with the PBM Defendants deterred companies from lowering prices. For example, following an April 2018 list price increase, Novo Nordisk began to face pressure from payors, the media, and Congress to reduce the prices of its insulin drugs. On May 29, 2018, Novo Nordisk's U.S. Pricing Committee debated whether it should reduce the list price of its insulin drugs by 50% after a string of news reports detailed how patients were struggling to afford their medications. Novo Nordisk understood that a 50% cut would be a meaningful reduction to patients, significantly narrow the list-to-net gap, head off negative press attention, and reduce "pressure" from Congressional hearings. However, Novo Nordisk was concerned that a list price reduction would pose significant financial risk to the company.

309. Novo Nordisk 's primary concerns were action from other entities in the pharmaceutical supply chain, many of which derive payments that are based on a percentage of a drug's WAC price. A PowerPoint slide created for this meeting suggests that the reasons not to lower prices were that "many in the supply will be negatively affected ($) and may retaliate" and that its "[c]ompetitors may not follow putting [Novo Nordisk] at a disadvantage."

[90] *Id.*



310. Despite these concerns, internal memoranda suggest that Novo Nordisk was still prepared to lower its list price by 2019 or 2020 if its "must haves" were met, which included an agreement from the PBMs that they would not retaliate against them by changing their formulary placement and would accept lower rebate percentages.

311. According to internal memoranda, Novo Nordisk's board of directors voted against this strategy in June 2018 and recommended that the company continue its reactive posture. The rationale for this decision was the "$33 million downside identified (NovoLog only)," "risk of payor [PBM] backlash or demand for current rebate on new NDC," and "high likelihood of immediate pressure to take similar

action on other products."[91] Following the decision by its board of directors, on August 30, 2018, Novo Nordisk decided to continue its strategy to "monitor the market . . . to determine if other major pharma companies are taking list price [increases]."[92]

312. Following years of rebate and list-price increases, the Manufacturers faced increased pressure from patients, payors, and the federal government to decrease insulin's list price. However, internal communications suggest that the downstream impact of lowering the list prices presented hurdles for pharmaceutical companies.

313. There is also evidence of direct communications between the Manufacturers and the PBM Defendants regarding lowering the prices of insulins. A June 23, 2018 email memorializes a conversation Eli Lilly's President of the Diabetes Unit, Enrique Conterno, had with the CEO of OptumRx, who allegedly "re-stated that [OptumRx] would be fully supportive of Lilly pursuing a lower list price option," but indicated that OptumRx would encounter challenges, namely, "the difficulty of persuading many of their customers to update contracts without offering a lower net cost to them." In response, an Eli Lilly executive noted, "we wouldn't be able to lower our list price without impacting our net price," and counseled waiting until

[91] *Id.* at 50.

[92] *Id.*

early 2020 to reduce prices. A few weeks earlier, Eli Lilly executives had raised the possibility that PBMs would object to a list price reset because it would result in a reduction of administrative fees for PBMs, reduce rebates which would impact PBMs' ability to satisfy rebate guarantees with some clients, and impair their clients' ability to lower premiums for patients, thereby impacting their market competitiveness.

314. Insulin price increases were also impacted by tactics the PBMs used in the early 2010s. At that time, the PBMs began to pressure the Manufacturers to raise list prices by implementing formulary exclusions in the insulin therapeutic class. When a drug is excluded, it means that it will not be covered by the insurer. Formulary exclusions effectively stop manufacturers from reaching large blocks of patients and require patients to either switch to a new product or pay more to stay on their preferred medication. This tactic boosted the size of rebates and supported the upward march of list prices. The Manufacturers responded to these formulary exclusion threats by raising list prices aggressively—increases that often were closely timed with price changes by competitors.

315. Internal communications confirm that PBM formulary exclusion lists have contributed to higher rebates in the insulin therapeutic class. The Manufacturers increased rebates in response to formulary exclusion threats and to preserve their revenue and market share through patient access. In addition, increases in rebates are

linked to increased list prices, meaning that the PBM defendants' demands for larger rebates directly contributed to rising insulin prices. As Eli Lilly's CEO, David Ricks, has explained, Eli Lilly agreed to raise list prices to fund higher rebates and fees for the PBMs:

> Getting on [a] formulary is the best way to ensure most people can access our medicines affordably—once again, that's how insurance is supposed to work. But that requires manufacturers to pay ever-increasing rebates and fees, which can place upward pressure on medicines' list prices. If we cannot offer competitive rebates, our medicines may be excluded from formularies, and people cannot access them. Last year alone, to ensure our medicines were covered, Lilly paid more than $12 billion in rebates for all our medicines, and $1 billion in fees. Last year, about eighty cents of every dollar spent on our insulins went to pay rebates and fees.

Insulin was among the first classes of drugs to face PBM formulary exclusions, and the number of insulins excluded has increased over time. In 2014, ExpressScripts and CVS Caremark excluded six and seven insulins, respectively. OptumRx excluded four insulins in 2016, its first year with an exclusion list. As of 2022, insulins have faced 193 total plan-years of exclusion across the PBMs since 2014.

316. The Manufacturers have also made price-increase decisions in response to pressures from their relationships with the PBMs. A higher list-price increases the dollar value of rebates, discounts, and other fees that a Manufacturer can offer to a PBM—all of which are based on a percentage of the list price. Internal documents show that the Manufacturers were sensitive not only to their own bottom lines, but

also to the bottom lines of PBMs that set formularies, without which a Manufacturer's product would likely lose significant market share.

317. Exclusions, driven in part by improper PBM incentives, have had a significant impact on patients' access to insulin. Lower list-priced insulins have been available since 2016—including follow-on insulins[93] (Admelog, Basaglar, Lyumjev, Fiasp), "authorized generic" insulins (Lispro, Insulin Aspart),[94] and, recently, biosimilar insulins. PBMs, however, often exclude these insulins from their formularies in favor of products with *higher* list prices and larger rebates. For example, two of the three PBM Defendants have excluded the two insulin authorized generics since 2020, instead favoring the higher list-priced equivalents. Remarkably,

[93] The term "follow-on biologic" is a broad term. The designation of "biosimilarity" is a regulatory designation and "follow-on biologics" are copies of originator innovator biologics. Those approved via the Biologics License Application (BLA) regulatory pathway (Public Health Service Act) are referred to as "biosimilars." Those approved via the New Drug Application (NDA) regulatory pathway (Food, Drug, and Cosmetic Act) retain the designation "follow-on" biologics. *See* Richard Dolinar, *et al.*, *A Guide to Follow-on Biologics and Biosimilars with a Focus on Insulin*, 24 Endocrine Practice 195-204 (Feb. 2018), available at https://www.sciencedirect.com/science/article/abs/pii/S1530891X20353982#:~:text=Follow%2Don%20biologics%20are%20copies,regulations%20involving%20biologics%20are%20complex (last visited Dec.. 17, 2025).

[94] An authorized generic medicine is a "brand name drug that is marketed without the brand name on its label." Additionally, "even though it is the same as the brand name product, a company may choose to sell the authorized generic at a lower cost than the brand name drug." *See Food and Drug Administration. FDA listing of authorized generics,* available at https://www.fda.gov/media/77725/download (last visited Dec. 17, 2025).

those PBM Defendants did so even though the list prices for these authorized generic insulins can be half the list price of the brand.[95]

318. In addition to the exclusions of authorized generic insulins, lower list-priced biosimilar insulins have also faced PBM formulary exclusions. The first biosimilar insulin was launched in 2021. Due to prevailing market dynamics, two identical versions of the product were simultaneously introduced—one with a higher list price and large rebates, and one with a lower list price and limited rebates—giving payors the option of which to cover. All three PBMs excluded the lower list-priced version in 2022, instead choosing to include the identical product with the higher list price.[96]

319. Excluding lower list-priced medicines from formularies can substantially increase out-of-pocket costs for patients in plans using deductibles or coinsurance, where cost-sharing is typically determined based on the medicine's full list price.[97]

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[95] Tori Marsh, *Is There a Humalog Generic? 5 Facts to Know About Admelog and Insulin Lispro*, GOODRX. (Aug. 26, 2019), available at https://www.goodrx.com/blog/admelog-now-cheaper-than-generic-humalog (last visited Dec. 17, 2025).

[96] Adam Fein, *Five takeaways from the big three PBMs' 2022 formulary exclusions* (Jan. 19, 2022), available at https://www.drugchannels.net/2022/01/five-takeaways-from-big-three-pbms-2022.html (last visited Dec. 17, 2025).

[97] Adam Fein, *Express Scripts vs. CVS Health: five lessons from the 2020 formulary exclusions and some thoughts on patient impact* (Jan. 14, 2020), available at https://www.drugchannels.net/2020/01/express-scripts-vs-cvs-health-five.html (last visited Dec. 17, 2025).

Favoring higher list-priced products has affected patient affordability and access to insulins.

320. The PBM Defendants and the Manufacturers are complicit in this. There has been little, if any, attempt by the PBM Defendants to discourage the Manufacturers from increasing the list price of their products. Instead, the PBMs used their size and aggressive negotiating tactics, such as the threat of excluding drugs from formularies, to extract higher rebates, discounts, and fees from the Manufacturers, who have increased their insulin list prices in lockstep.

321. The PBMs thus had every incentive to encourage the Manufacturers to raise list prices, since the rebates, discounts, and fees the PBMs negotiate are based on a percentage of a drug's list price—and the PBMs retain a large portion of what they negotiate. In fact, the Manufacturers have been dissuaded from decreasing list prices for their products, which would have lowered out-of-pocket costs for patients, due to concerns that the PBMs and health plans would react negatively.

322. Diabetes medications have become unaffordable for many diabetics because of the Manufacturer and PBM Defendants' collusive price increases.

C. The Pharmaceutical Payment and Supply Chains

323. The prescription drug industry is comprised of a deliberately complex network of entities engaged in multiple distribution and payment structures with little to no transparency. These entities include manufacturers, wholesalers, PBMs,

pharmacies, payors, and patients.

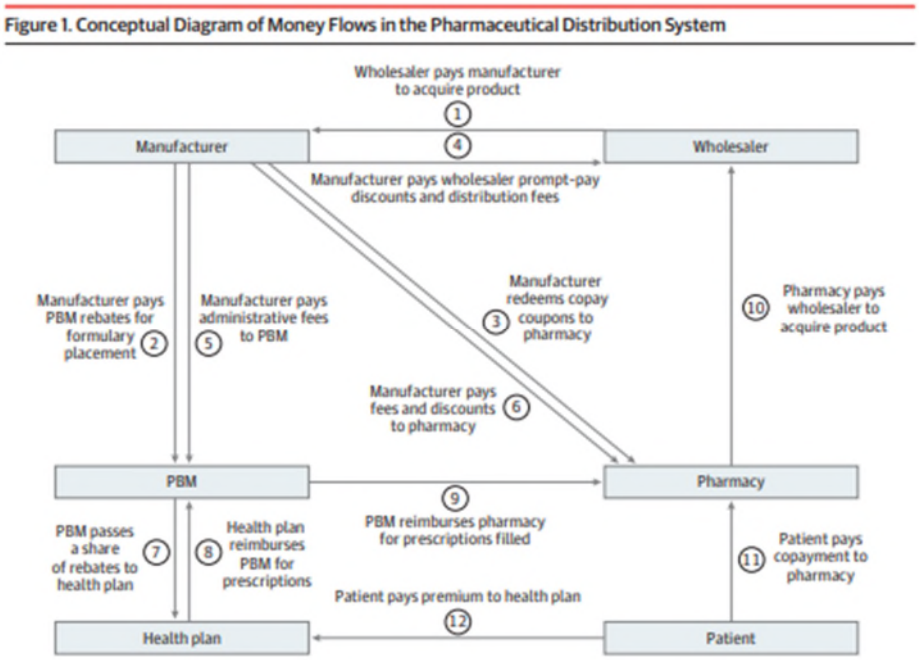
324. Given the complexities of the different parties involved in the pharmaceutical industry, pharmaceuticals are distributed in many ways. Generally speaking, branded prescription drugs, such as the at-issue diabetes medications, are distributed in one of three ways: (a) from manufacturer to wholesaler (distributor), wholesaler to pharmacy, and pharmacy to patient; (b) from manufacturer to mail-order pharmacy to patient; or (c) from manufacturer to mail-order pharmacy, mail-order pharmacy to self-insured payor, and self-insured payor to patient.

325. The pharmaceutical industry is unique in that the payment chain is not the same as the distribution chain. The prices for the drugs distributed in the pharmaceutical chain are different for each participating entity—that is, different actors pay different prices set by different entities for the same drugs. The unifying factor is that the price that each entity in the pharmaceutical chain pays for a drug is necessarily tied to the price set by the manufacturer.

326. Here is how the payment chain often works:[98]

[98] *See* Karen Van Nuys, et al., Estimation of the Share of Net Expenditures on Insulin Captured by US Manufacturers, Wholesalers, Pharmacy Benefit Managers, Pharmacies, and Health Plans From 2014 to 2018, JAMA HEALTH FORUM (Nov. 5, 2021), available at https://jamanetwork.com/journals/jama-health-forum/fullarticle/2785932 (last visited Dec. 17, 2025).

Figure 12: The pharmaceutical payment chain



327. The payment chain includes self-insured payors like Plaintiffs paying inflated prices for at-issue drugs to PBMs and manufacturers.

328. But there is no transparency in this pricing system. Typically, there are two kinds of published prices. One is the WAC, which is a manufacturer's price for the drug to wholesalers (and excludes any discounts, rebates, or price reductions). The other is the AWP, which is the price wholesalers charge retailers for a drug. Both WAC and AWP, depending on the context, can be referred to as "list price."[99]

329. AWP is usually calculated by applying a significant mark-up (such as

[99] In general, when this complaint references Defendants' conspiracy to inflate "list prices," Plaintiff is referring to WAC. Because AWP is based on WAC, when a manufacturer raises its WAC, that necessarily results in an increase to the AWP.

20%) to the manufacturer's WAC. AWP does not account for discounts available to various payers, nor is it based on actual sales transactions.

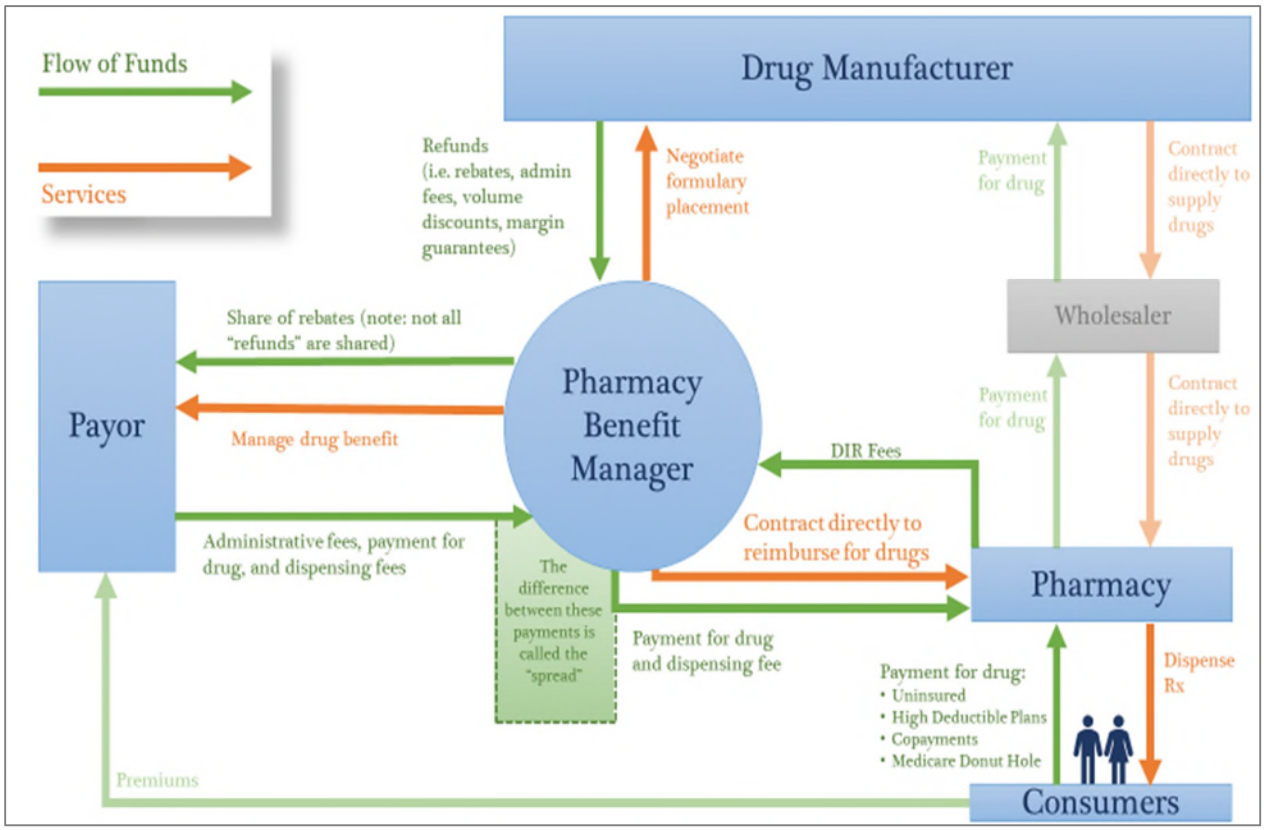
330. Publishing compendia such as First DataBank report both the WAC and the AWP.

331. As a direct result of the PBMs' conduct, AWP persists as the most commonly and continuously used benchmark price in negotiating reimbursement and payment calculations for both payors and patients.

D. The PBMs' Role in the Pharmaceutical Payment Chain

332. The PBMs are at the center of the pharmaceutical payment chain, as illustrated in Figure 13 below.

Figure 13: Insulin distribution and payment chain



333. Pharmacy benefit managers develop drug formularies, process claims, create networks of retail pharmacies, coordinate with manufacturers to set the prices that payors will pay for prescription drugs, and are compensated by the payors for the drugs used by their beneficiaries.

334. The PBMs also contract with a network of retail pharmacies. Pharmacies agree to dispense drugs to patients and pay fees back to the PBMs. The PBMs reimburse pharmacies for the drugs dispensed.

335. The PBMs also own mail-order and specialty pharmacies, which purchase and take possession of prescription drugs, including those at-issue here, and

directly supply those drugs to patients by mail.

336. Often—including for the at-issue drugs—the PBM Defendants purchase drugs directly from the Manufacturers and distribute them directly to the patients.

337. Even where the PBM Defendants' mail-order pharmacies purchase drugs from wholesalers, their costs are set by direct contracts with the manufacturers.

338. In addition, and of particular significance here, the PBM Defendants contract with drug manufacturers, including the Manufacturer Defendants. The PBMs extract from the Manufacturers rebates, fees, and other consideration that are paid back to the PBM, including the Manufacturer Payments related to the at-issue drugs.

339. PBMs are at the center of the flow of pharmaceutical money which allows them to exert tremendous influence over what drugs are available nationwide, on what terms, and at what prices.

340. Historically and today, the PBM Defendants:

- negotiate the price that payors pay for prescription drugs (based on prices generated by the Insulin Pricing Scheme);
- separately negotiate a different (and very often lower) price that pharmacies in their networks receive for the same drug;
- set the amount in fees that the pharmacy pays back to the PBM for each drug sold (based on prices generated by the Insulin Pricing Scheme);
- set the price paid for each drug sold through their mail-order pharmacies (based on prices generated by the Insulin Pricing Scheme); and

- negotiate the amount that the Manufacturers pay back to the PBM for each drug sold (based on prices generated by the Insulin Pricing Scheme).

341. Yet, for the majority of these transactions, only the PBMs are aware of the amount that any other entity in this supply chain is paying or receiving for the same drugs. This utter absence of transparency affords Defendants the opportunity to extract billions of dollars from this payment and supply chain without detection.

342. In every interaction the PBMs have within the pharmaceutical payment chain, they stand to profit from the prices generated by the Insulin Pricing Scheme.

343. In the 1960s, pharmacy benefit managers functioned largely as claims processors. Over time, however, they have assumed an ever-expanding role as power brokers in pharmaceutical payment and distribution chains.

344. One key role pharmacy benefit managers assumed was negotiating with drug manufacturers, supposedly on behalf of payors. In doing so, pharmacy benefit managers affirmatively represented that they were using their leverage to drive down drug prices.

345. In the early 2000s, pharmacy benefit managers started buying pharmacies, thereby creating an incentive to collude with manufacturers to keep certain prices high.

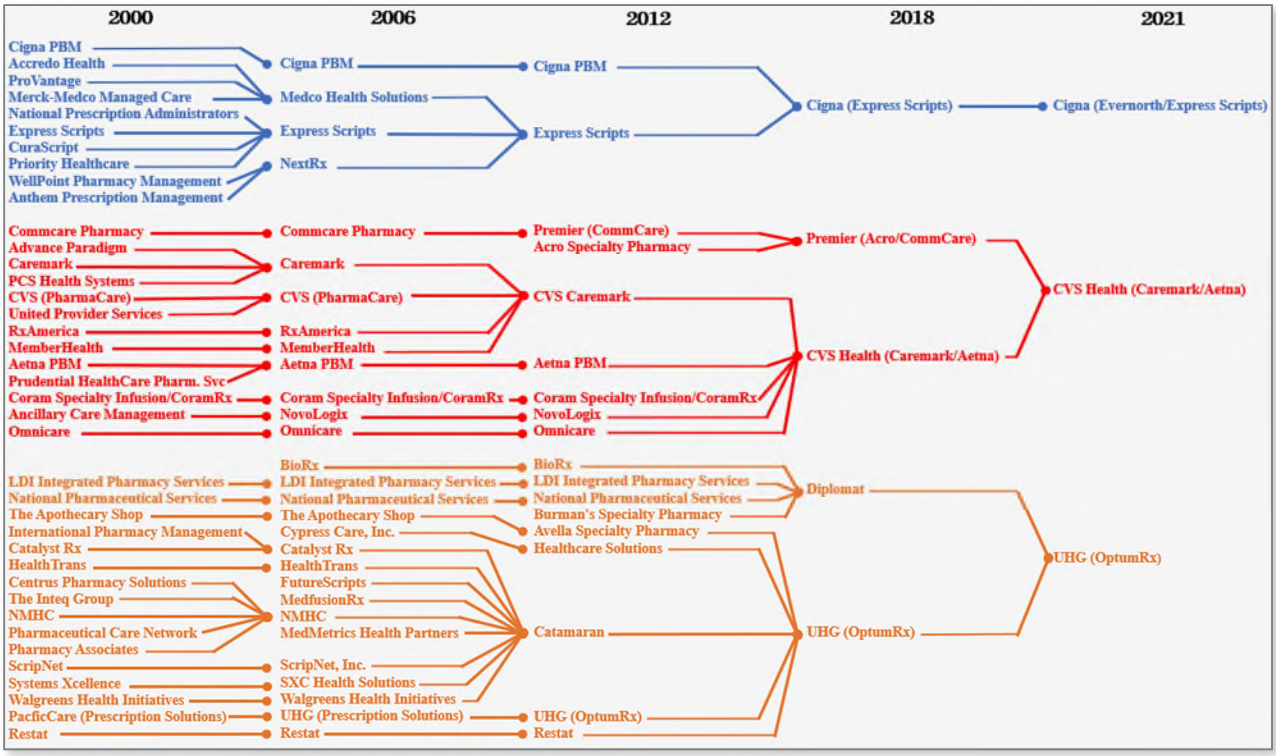
346. These incentives still exist today with respect to both retail and mail-order pharmacies that are a part of the PBMs' corporate families. Further recent

consolidation in the industry has given the PBMs disproportionate market power.

347. Nearly forty pharmacy-benefit-manager entities merged to form what are now the PBM Defendants, each of which is affiliated with another significant player in the pharmaceutical chain—for example, Express Scripts merged with Cigna; CVS acquired Caremark (and now also owns Aetna); and UnitedHealth Group acquired OptumRx.

348. Figure 14 depicts this market consolidation.

Figure 14: PBM consolidation



349. After merging with or acquiring all competitors, and now backed by multibillion-dollar corporations, the PBM Defendants have taken over the market in the past decade, controlling more than 80% of drug benefits for more than 270 million

Americans.

350. Together, the PBM Defendants report more than $300 billion in annual revenue.

351. The PBMs use this market consolidation and the resulting purchasing power as leverage when negotiating with other entities in the pharmaceutical payment chain.

352. The insular nature of the pharmaceutical industry has provided Defendants with ample opportunity for contact and communication with their competitors, as well as the other PBM and Manufacturer Defendants, which facilitates their execution of the Insulin Pricing Scheme.

353. Each Manufacturer Defendant is a member of the industry-funded Pharmaceutical Research and Manufacturers of America ("PhRMA") and has routinely communicated through PhRMA meetings and platforms about the Insulin Pricing Scheme. According to PhRMA's 2019 IRS Form 990, it received more than $515 million in "membership dues" from its members, who are pharmaceutical companies.[100]

354. David Ricks (Chair and CEO of Eli Lilly), Paul Hudson (CEO of Sanofi),

[100] PhRMA 2019 Form 990, https://projects.propublica.org/nonprofits/organizations/530241211/202043189349300519/full (last visited Dec. 17, 2025); PhRMA, *About PhRMA*, https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Org/PDF/A-C/About-PhRMA2.pdf (last visited Dec. 17, 2025).

and Douglas Langa (President of Novo Nordisk and EVP of North American Operations), serve on the PhRMA Board of Directors and/or part of the PhRMA executive leadership team.

355. The PBM Defendants also routinely communicate through direct interaction with their competitors and the Manufacturers at trade associations and industry conferences.

356. Each year during the relevant period, the main PBM trade association––the industry-funded Pharmaceutical Care Management Association ("PCMA")—held several yearly conferences, including the Annual Meeting and its Business Forum conferences.[101]

357. The PCMA is governed by PBM executives. As of April 2024, the board of the PCMA included Adam Kautzner (President of Express Scripts), Patrick Conway (CEO of OptumRx), and David Joyner (Executive Vice President and President of Pharmacy Services at CVS Health).

358. All PBM Defendants are members of the PCMA and, due to their leadership positions, have substantial control over it.

359. The Manufacturer Defendants are affiliate members of the PCMA.

[101] The PCMA's industry funding in the form of "membership dues" is set out in its 2019 Form 990, https://projects.propublica.org/nonprofits/organizations/383676760/202042969349301134/full (last visited Dec. 17, 2025).

360. Every year, high-level representatives and corporate officers from both the PBM and Manufacturer Defendants attend these conferences to meet in person and have communications, including those in furtherance of the Insulin Pricing Scheme.

361. Many of the forums at these conferences are specifically advertised as offering opportunities for private, non-public communications. For example, as Presidential Sponsors of these conferences, Manufacturer Defendants each hosted "private meeting rooms" that offer "excellent opportunities for . . . one-on-one interactions between PBM and pharma executives."[102]

362. Representatives from each Manufacturer Defendant have met privately with representatives from PBM Defendants during the Annual Meetings and Business Forum conferences that the PCMA holds (and the manufacturers sponsor) each year.

363. In addition, all PCMA members, affiliates and registered attendees of these conferences are invited to join PCMA-Connect, "an invitation-only LinkedIn

[102] PCMA, *The PCMA Annual Meeting 2021 Will Take Place at the Broadmoor in Colorado Springs, CO September 20 and 21*, available at https://www.pcmanet.org/events/past-events/pcma-annual-meeting-2021/ (an event "tailored specifically for senior executives from PBMs and their affiliated business partners" with "private reception rooms" and "interactions between PBM members, drug manufacturers, and other industry partners") (last visited Dec. 18, 2025).

Group and online networking community."[103]

364. As PCMA members, the PBM Defendants and Manufacturer Defendants likely used both PCMA-Connect, as well as the private meetings at the PCMA conferences, to exchange information and to reach agreements in furtherance of the Insulin Pricing Scheme.

365. Key at-issue lockstep price increases occurred immediately after Defendants had convened at PCMA meetings. For example, on September 26–27, 2017, PCMA held its annual meeting, during which each Manufacturer Defendant hosted a private room, and their executives participated in multiple meetings throughout the conference. On October 1, 2017, just days after the conference, Sanofi increased Lantus's list price by 3% and Toujeo's list price by 5.4%. Novo Nordisk recommended that their company make a 4% list price increase effective on January 1, 2018, to match the Sanofi increase.

366. Also on May 30, 2014, Novo Nordisk raised the list price of Levemir hours after Sanofi increased the price of Lantus. These price hikes occurred just weeks after the 2014 PCMA spring conference in Washington, D.C., attended by representatives of all three PBM Defendants.

367. The PBMs control the PCMA and have used it to further their interests

[103] PCMA, *PCMA-Connect*, available at https://www.pcmanet.org/contact/pcma-connect/ (last visited Dec. 18, 2025).

and to conceal the Insulin Pricing Scheme. The PCMA has instituted numerous lawsuits and lobbying campaigns aimed at blocking drug pricing transparency efforts.

368. The PCMA's 2019, 2020, and 2021 tax returns report annual revenue for "litigation support" totaling $1.01 million, $2.19 million, and $2.92 million respectively. Prior tax returns similarly reveal millions of dollars in revenue for "litigation support" (and tens of millions in revenue for "industry relations") year after year.[104]

369. In addition, communications among the PBM Defendants are facilitated by the movement of executives between PBM Defendants. For example:

- Mark Thierer worked as an executive at Caremark Rx, LLC (now CVS Caremark) prior to becoming the CEO of OptumRx in 2016 (and also served as Chairman of the Board for PCMA starting in 2012);
- CVS Health's current President and CEO Karen Lynch held an executive position at Cigna;
- Amar Desai served as President for Health Care Delivery at CVS Health before joining Optum Health, where he now serves as CEO.
- Trip Hofer served in leadership at CVS Health before becoming CEO of Behavioral Health for Optum Health.
- Bill Wolfe was the President of the PBM Catalyst Rx (now OptumRx) prior to becoming the President of Aetna Rx in 2015 (and also served as a PCMA board member from 2015-2017 while with Aetna Rx);
- Derica Rice former EVP for CVS Health and President of CVS Caremark

[104] *See, e.g.*, PCMA 2019-2021 Form 990s and prior years' returns on ProPublica, available at https://projects.propublica.org/nonprofits/organizations/472487430 (last visited Dec. 18, 2025).

previously served as EVP and CFO for Eli Lilly;

- Duane Barnes was the Vice President of Medco (now Express Scripts) before becoming division President of Aetna Rx in 2006 (and also served as a PCMA board member);
- Everett Neville was the division President of Aetna Rx before becoming Senior Vice President of Express Scripts;
- Albert Thigpen was a Senior Vice President at CVS Caremark for eleven years before becoming a Senior Vice President at OptumRx in 2011;
- Harry Travis was the Chief Operating Officer at Medco (now Express Scripts) before becoming a Vice President at Aetna Rx in 2008; he also served as SVP Member Services Operations for CVS Caremark from 2020-2022; and
- Bill Kiefer was a Vice President of Express Scripts for fourteen years before becoming Senior Vice President of Strategy at OptumRx in 2013.

E. The Insulin Pricing Scheme

370. The market for the at-issue diabetes medications is unique in that it is highly concentrated with no true generics and few biosimilar options. The drugs and biosimilars have similar efficacy and risk profiles.

371. This affords the PBMs significant leverage that, in theory, could be used to negotiate with the Manufacturer Defendants to drive *down* list prices for the at-issue drugs through open competition.

372. But the PBMs do not want to drive down the prices for diabetes medications. A 2022 report by the Community Oncology Alliance states:

> Among the different sources of revenue, the most prolific by far is in the form of rebates from pharmaceutical manufacturers that PBMs extract in exchange for placing the manufacturer's product drug on a plan sponsor's formulary or encouraging utilization of the manufacturer's drugs. . . . [T]he growing number and scale of rebates is the primary fuel of today's high drug prices. The truth is that PBMs

> have a vested interest to have drug prices remain high, and to extract rebates off of these higher prices. PBM formularies tend to favor drugs that offer higher rebates over similar drugs with lower net costs and lower rebates.[105]

373. The Senate Insulin Report confirms, after committee review of internal documents produced by the Manufacturer Defendants, that Manufacturer Defendants understand that they make more money as list prices increase. They also understand that PBM Defendants make more money as list prices increase. [106]

374. The documents eventually released by the Senate Finance Committee also indicate how the Manufacturer Defendants' pricing strategy focuses on the PBMs' profitability. In an internal August 6, 2015, email, Novo Nordisk executives debated delaying increasing the price of an at-issue drug to make the increase more profitable for CVS Caremark, stating:

> Should we take 8/18 [for a price increase], as agreed to by our [pricing committee], or do we recommend pushing back due to the recent CVS concerns on how we take price? . . . We know CVS has stated their disappointment with our price increase strategy (ie taking just after the 45th day) and how it essentially results in a lower price protection, admin fee and rebate payment for that quarter/time after

[105] Community Oncology Alliance & Frier Levitt, Pharmacy Benefit Manager Exposé: How PBMs Adversely Impact Cancer Care While Profiting at the Expense of Patients, Providers, Employers, and Taxpayers (Feb. 2022), available at https://communityoncology.org/wp-content/uploads/2022/02/COA_FL_PBM_Expose_2-2022.pdf (last visited Dec. 18, 2025).

[106] Senate Insulin Report *supra* note 7.

our increase . . . it has been costing CVS a good amount of money.[107]

375. The Manufacturer Defendants also understand that because of the PBMs' market dominance, most payors accept the baseline national formularies offered by the PBMs with respect to the at-issue drugs.

376. The Insulin Pricing Scheme grew out of these understandings. Both sets of Defendants realized that if the Manufacturers artificially inflated their list prices to facilitate large, undisclosed Manufacturer Payments back to the PBMs, both the PBMs and Manufacturers would generate billions of unearned dollars. The plan worked.

377. Over the past several years the Manufacturers have raised prices in unison and have paid correspondingly larger Manufacturer Payments to the PBMs.

378. In exchange for the Manufacturers artificially inflating their prices and paying the PBMs substantial amounts in Manufacturer Payments, the PBM Defendants grant the Manufacturer Defendants' diabetes medications elevated prices and preferred status on their national formularies. During the relevant period, the rebate amounts (as a proportion of the list price) grew on a yearly basis while list prices themselves increased.

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[107] Letter from Raphael A. Prober, Counsel for Novo Nordisk Inc., to Charles E. Grassley & Ron Wyden, S. Fin. Comm. (Mar. 8, 2019), available at https://www.finance.senate.gov/imo/media/doc/Novo_Redacted.pdf (last visited Dec. 18, 2025).

379. Beyond increased rebate demands, the PBM Defendants have also sought and received larger administrative fees from the Manufacturers during the relevant period.

380. A study by the Pew Charitable Trust estimated that, between 2012 and 2016, the amount of administrative and other fees that the PBMs requested and received from the Manufacturers tripled, reaching more than $16 billion. The study observed that although rebates were sent to payors during this period, PBMs retained the same volume of rebates in pure dollars, due to the overall growth in rebate volume, as well as increases in administrative fees and spread pricing, where the PBM charges a client payor more for a drug than the PBM pays the pharmacy and the PBM keeps the difference or "spread."

381. Thus—and contrary to their public representations—the PBM Defendants' negotiations and agreements with the Manufacturer Defendants (and the formularies that result from these agreements) have caused and continue to cause price increases for the at-issue drugs.

382. As a result of the Insulin Pricing Scheme, every payor, including Plaintiffs, that pays or reimburses for the at-issue drugs has been overcharged.

383. Moreover, the PBMs use this false price to misrepresent the amount of "savings" they generate for diabetics, payors, and the healthcare system.

384. In making representations about savings, the PBMs do not disclose that

the amount of "savings" generated is calculated based on the false list price, which is not paid by any entity in the pharmaceutical payment chain and which all Defendants are directly responsible for artificially inflating.

385. The Insulin Pricing Scheme is a coordinated effort between the Manufacturer and PBM Defendants that created enormous profits for Defendants. Each of the Defendants agreed to and participated in the scheme. For example:

- The Manufacturers and the PBMs are in constant communication and regularly meet and exchange information to construct and refine the PBM formularies that form and fuel the scheme. As part of these communications, the Manufacturers are directly involved in determining not only where their own diabetes medications are placed on the PBMs' formularies and with what restrictions, but also in determining the same for competing products. Though communications and written contracts, the Manufacturers and the PBMs also agree to rebates, fees, and other payments—that is, kickbacks—in exchange for preferred formulary access.
- The Manufacturers and the PBMs share confidential and proprietary information with each other in furtherance of the Insulin Pricing Scheme, such as market data gleaned from the PBMs' drug utilization tracking efforts and mail-order pharmacy claims, internal medical efficacy

studies, and financial data. Defendants then use this information in coordination to set the false prices for the at-issue medications and to construct their formularies in the manner that is most profitable for both sets of Defendants. The data that is used to further this coordinated scheme is compiled, analyzed, and shared either by departments directly housed within the PBM or by subsidiaries of the PBM, as is the case with OptumRx (which utilizes OptumInsight and Optum Analytics).

- The Manufacturers and the PBMs engage in coordinated outreach programs directly to patients, pharmacies, and prescribing physicians to convince them to switch to the diabetes medications that are more profitable for the PBMs and Manufacturers, even drafting and editing letters in tandem to send out to diabetes patients on behalf of the PBMs' clients.

386. Rather than using their bargaining power to lower drug prices as they claim, Defendants used their dominant positions to work together to generate billions of dollars in illicit profits at the expense of payors and diabetics.

F. The Manufacturers React to Threats of Formulary Exclusion by Increasing Rebates Offered to the PBMs

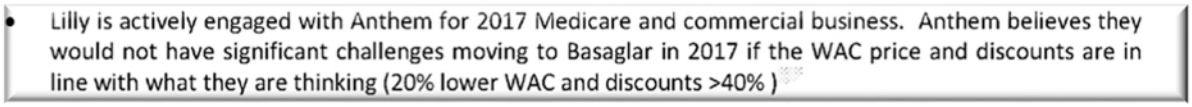
387. Although the PBM Defendants have insisted they had no control over how the Manufacturers price their insulin products, their threats of formulary exclusion illustrate how they used new insulin competitors with lower prices to

leverage even higher rebates on the existing insulin drugs.

388. In the face of formulary exclusion threats based on new entrants in the insulin market, the Manufacturers have willingly met the PBM Defendants' demands for increased rebates to retain preferred formulary placement and block competitors. For example, in 2016, Sanofi and Novo Nordisk enhanced their rebate offers at the same time Eli Lilly introduced Basaglar, a follow-on biologic to Lantus. Basaglar is a long-acting insulin and is "[c]linically . . . very similar" to Sanofi's Lantus. Because of its near clinical equivalence, Basaglar posed a competitive threat in the long-acting insulin market. The PBMs threatened to switch to Basaglar because it was priced lower and they expected Eli Lilly to offer larger discounts in response.

389. A 2016 Sanofi memo describes the market dynamic whereby a threatened new market entrant would lead not to lower prices, but to greater rebates:

Figure 15: Sanofi memo on introduction of Basaglar



390. In an attempt to avoid PBMs switching to Basaglar, Sanofi and Novo Nordisk increased their rebate bids to respond to Eli Lilly. For example, according to Sanofi internal memoranda, sometime around April 2016, Express Scripts requested bids for its 2017 national commercial formulary and indicated its desire to add only one insulin glargine product to its basal insulin category. Express Scripts

communicated to Sanofi that "with the right competitive price, [it] would not have significant challenges moving [from Lantus and Toujeo] to Basaglar" and that Sanofi must enhance its current rebate rate of 42% to maintain access for their basal insulins.[108]

391. An internal Sanofi memo describes the dynamic where, at "the right competitive price," Express Scripts would not have a challenge moving Basaglar into a preferred position on its formulary:[109]

Figure 16: Sanofi memo on Basaglar pricing

Likely Competitive Approach and Response:

- Lilly is actively engaged with ESI for 2017 commercial business. Pricing has not been confirmed however ESI has informed that the following assumptions pose a threat to Sanofi's glargine franchise:
  - Discounts for Basaglar in the mid 60's have been communicated by ESI to Sanofi. This is likely a starter for ESI to consider excluding Lantus and Toujeo. Modeling assumed 70%.
  - Basaglar WAC will be 15% to 25% less than the WAC price of Lantus. Sanofi modeling assumed 15%.
- ESI has signaled, with the right competitive price, they would not have significant challenges moving to Basaglar in 2017 despite a follow-on biologic (Basaglar) approval.
- In addition ESI has indicated that Novo must also enhance its current rate to maintain current access for their basal insulin(s). Novo is likely to enhance its current rebates given recent Tresiba addition to part D formulary.

392. Rebate contracts confirm that Sanofi increased its offer up to almost 55% off its WAC of $248.51 for Lantus vials and $372.76 for Lantus pens.

393. For the Manufacturers, the mere threat of exclusion exerts significant pressure on them to offer substantially greater rebates to maintain formulary position. This is because formulary exclusions are likely to cause significant loss of a

[108] Insulin Senate Report *supra* note 7, at 61.

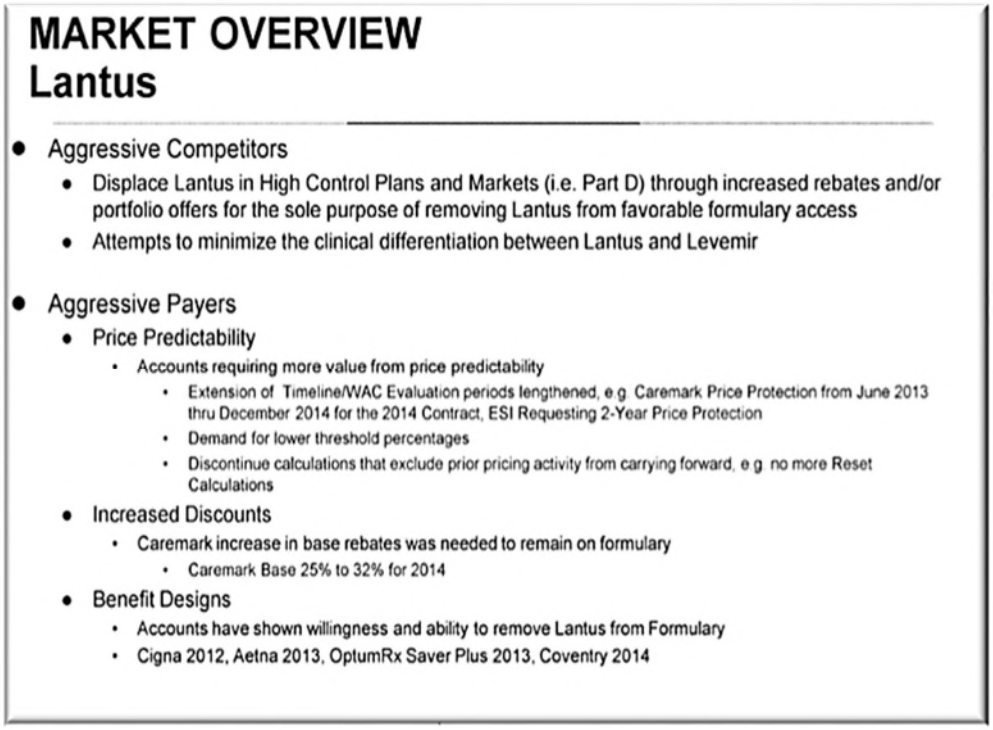
[109] *Id.*

manufacturer's market share, leading to lower revenue. On the other hand, being exclusive therapy on a formulary has the opposite effect, which incentivizes Manufacturers to offer large discounts to acquire or maintain such status. The use of formulary exclusions has thus led to a market dynamic in which Manufacturers offer ever-higher rebates to avoid exclusion, which has led to higher list prices.

394. For example, before 2013, Sanofi offered an average rebate of 5% on Lantus. However, beginning in 2013, competitors sought to "[d]isplace Lantus in High Control Plans and Markets . . . through increased rebates" to capture market share.[110] In response, Sanofi increased its rebate and discount offerings to remain on their formulary. A Sanofi memo further explains this dynamic:

[110] *Id.* at 67.

Figure 17: Sanofi memo on increased rebates for Lantus



MARKET OVERVIEW
Lantus

- Aggressive Competitors
  - Displace Lantus in High Control Plans and Markets (i.e. Part D) through increased rebates and/or portfolio offers for the sole purpose of removing Lantus from favorable formulary access
  - Attempts to minimize the clinical differentiation between Lantus and Levemir
- Aggressive Payers
  - Price Predictability
    - Accounts requiring more value from price predictability
      - Extension of Timeline/WAC Evaluation periods lengthened, e.g. Caremark Price Protection from June 2013 thru December 2014 for the 2014 Contract, ESI Requesting 2-Year Price Protection
      - Demand for lower threshold percentages
      - Discontinue calculations that exclude prior pricing activity from carrying forward, e.g. no more Reset Calculations
  - Increased Discounts
    - Caremark increase in base rebates was needed to remain on formulary
      - Caremark Base 25% to 32% for 2014
  - Benefit Designs
    - Accounts have shown willingness and ability to remove Lantus from Formulary
    - Cigna 2012, Aetna 2013, OptumRx Saver Plus 2013, Coventry 2014

395. While the PBM Defendants have touted that using formulary exclusions in the insulin therapeutic class was a way to drive down costs for their clients, internal correspondence and memoranda show that increased use of formulary exclusions did just the opposite: WAC (list) prices have continued to increase, leading to higher costs for payors and higher prices for patients at the pharmacy counter.

396. For example, in 2013, when Express Scripts threatened to move patients to other diabetes drugs to "break even on [the] rebate line" unless Sanofi increased its Medicare Part D rebate offer for Lantus, Sanofi considered increasing its rebate offer from 7.45% to 15% in order to prevent formulary exclusion.[111] Sanofi also faced

[111] *Id.*

similar pressure to increase rebates for Express Scripts' commercial contracts. Internal Sanofi memoranda show that "Sanofi was notified by [Express Scripts] that Lantus was positioned to be removed from the formulary effective 2013 . . . [and as a result] rebates were re-negotiated."[112]

397. According to internal memoranda, in 2014, Express Scripts and its affiliated businesses managed the prescription drug claims of over 4.6 million people, representing 15% of the total Medicare Part D business. Rebate agreements confirm Sanofi renegotiated rebates and entered into an agreement to provide up to 10.625% for Lantus, effective January 1, 2014. Rebates were renegotiated again that same year, and Sanofi increased its rebate offer up to 14.625%, effective October 1, 2014.

398. CVS Caremark and OptumRx used similar formulary exclusion threats to drive up Lantus rebates. Around this same time, other PBMs learned that Sanofi had offered competitive rebates to Express Scripts which caused them to question their rebate status with Lantus. As a result, they demanded higher rebates and threatened to exclude Lantus from their formulary to achieve this result.

399. For example, in 2014, OptumRx threatened to remove Lantus from its commercial formulary. Sanofi offered an enhanced rebate for FY2015 in the 15% range, but OptumRx rejected Sanofi's offer and took steps to remove Lantus from its commercial formulary. Sanofi responded with a last-minute bid of a 45% rebate for

[112] *Id.* at 68.

Tier 2, which OptumRx countered with 45% for Tier 3. According to Sanofi, OptumRx's counteroffer was "ultimately accepted over access concerns to future products and the need to secure access to patient lives."[113]

400. Similarly, in 2016, Express Scripts threatened to remove Lantus and Toujeo from its Medicare Part D formulary and requested that Sanofi submit its "best and final offer" or else face formulary exclusion. According to internal memoranda, during negotiations, Express Scripts told Sanofi that it was justified in removing Lantus and Toujeo from its Medicare Part D formulary because it had allowed "quite a few years of price increases" and that Novo Nordisk's rebate offer was more competitive. In response to Express Scripts' threat, Sanofi discussed revising its rebate offer up to 40% with 4% price protection for Lantus and Toujeo.[114]

401. Although contracts with PBMs included larger rebates, the Manufacturers still expected to remain profitable.

402. As the PBMs expanded the practice of using formulary exclusions to extract greater rebates, Sanofi's counterstrategy was to bundle unrelated products that had been excluded—Lantus and an epinephrine injection called Auvi-Q—to win formulary inclusion for both. Bundling is where manufacturers offer rebates and discounts for multiple products, but only if certain conditions are met.

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[113] *Id.* at 69.

[114] *Id.*

403. Sanofi faced significant financial pressure across all accounts and sought to include bundling agreements in several of its contracts. While negotiating contracts for the 2015/16 plan year, Express Scripts advised Sanofi that it needed to be far more aggressive with rebate offers to gain access to the PBM's commercial book of business than in past years.

404. Novo Nordisk secured contract terms from CVS Caremark's Part D business in 2013 that tied its "exclusive" rebates for insulin to formulary access for its Type 2 diabetes drug Victoza. The exclusive rebates of 57.5% for Novolin, Novolog, and Novolog Mix 70/30 were more than three times higher than the 18% rebate for plans that included two insulin products on their formulary. To qualify for the exclusive rebate, the plans would also need to list Victoza, a GLP-1 agonist, on their formulary, exclude all competing insulin products, and ensure "existing patients using a [c]ompeting [p]roduct may not be grandfathered."[115]

G. Defendants Downplay the Insulin Pricing Scheme

405. On April 10, 2019, the U.S. House of Representatives Committee on Energy and Commerce held a hearing on industry practices titled, "Priced Out of a Lifesaving Drug: Getting Answers on the Rising Cost of Insulin."[116]

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[115] *Id.* at 71.

[116] Priced Out of a Lifesaving Drug: Getting Answers on the Rising Cost of Insulin, *Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce*, 116th Cong. (Apr. 10, 2019), available at

406. Representatives from all Defendants testified at the hearing and admitted that the price for insulin had increased exponentially over the past fifteen years.

407. Defendants each also conceded that the price that diabetics pay out-of-pocket for insulin is too high. For example:

- Dr. Sumit Dutta, SVP and Chief Medical Officer of OptumRx since 2015, testified: "A lack of meaningful competition allows the [M]anufacturers to set high [list] prices and continually increase them which is odd for a drug that is nearly 100 years old and which has seen no significant innovation in decades. These price increases have a real impact on consumers in the form of higher out-of-pocket costs."

- Thomas Moriarty, General Counsel for CVS admitted: "A real barrier in our country to achieving good health is cost, including the price of insulin products which are too expensive for too many Americans. Over the last several years, prices for insulin have increased nearly 50 percent. Over the last ten years, [the] list price of one product, Lantus, rose by 184 percent."

- Mike Mason, Senior Vice President of Eli Lilly, testified when discussing how much diabetics pay out-of-pocket for insulin: "[I]t's difficult for me to hear anyone in the diabetes community worry about the cost of insulin. Too many people today don't have affordable access to chronic medications."

- Kathleen Tregoning, Executive Vice President for External Affairs at Sanofi, testified: "Patients are rightfully angry about rising out-of-pocket costs for many medicines and we all have a responsibility to address a system that is clearly failing too many people. . . . [W]e recognize the need to address the very real challenges of affordability. . . . [S]ince 2012, average out-of-pocket costs for Lantus have risen approximately 60 percent for patients."

- Doug Langa, Executive Vice President of Novo Nordisk, testified: "On

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https://www.congress.gov/event/116th-congress/house-event/109299 (last visited Dec. 18, 2025).

> the issue of affordability, . . . I will tell you that at Novo Nordisk we are accountable for the list prices of our medicines. We also know that list price matters to many, particularly those in high-deductible health plans and those that are uninsured."

408. None of the testifying Defendants claimed that the significant increase in the price of insulin was related to competitive factors such as increased production costs or improved clinical benefit.

> Instead, the written testimony of Novo Nordisk President Doug Langa recognized "misaligned incentives" that have led to higher drug costs, including for insulin: "Chief among these misaligned incentives is the fact that the rebates pharmaceutical companies pay to PBMs are calculated as a percentage of WAC [list] price. That means a pharmaceutical company fighting to remain on formulary is constrained from lowering WAC price, or even keeping the price constant, if a competitor takes an increase. This is because PBMs will then earn less in rebates and potentially choose to place a competitor's higher-priced product on their formulary to the exclusion of others." Likewise, Mr. Langa's responses to questions for the record conceded that "[t]he disadvantage of a system in which administrative fees are paid as a percentage of the list price is that there is increased pressure to keep list prices high."

409. Eli Lilly admitted that it raises list prices as a quid pro quo for formulary positions. At the April 2019 Congressional hearing, Mike Mason, Senior Vice President of Eli Lilly, testified:

> Seventy-five percent of our list price is paid for rebates and discounts . . . . $210 of a vial of Humalog is paid for discounts and rebates. . . . We have to provide rebates [to PBMs] in order to provide and compete for that [formulary position] so that people can use our insulin.

In the very next question, Mr. Langa of Novo Nordisk was asked, "[H]ave you ever lowered a list price?" His answer, "We have not."

410. Sanofi's Executive Vice President for External Affairs, Kathleen Tregoning, similarly testified:

> The rebates [are] how the system has evolved. . . . I think the system became complex and rebates generated through negotiations with PBMs are being used to finance other parts of the healthcare system and not to lower prices to the patient.

Her written response to questions for the record acknowledged that "it is clear that payments based on a percentage of list price result in a higher margin [for PBMs] for the higher list price product than for the lower list price product."

411. The PBM Defendants also conceded at the April 2019 Congressional hearing that they grant preferred, or even exclusive, formulary position because of higher Manufacturer Payments paid by the Manufacturer Defendants.

412. In her responses to questions for the record, Amy Bricker—former President of Express Scripts and a former PCMA board member—confirmed that "manufacturers lowering their list prices" would give patients "greater access to medications." Yet when asked to explain why Express Scripts did not grant an insulin with a lower list price preferred formulary status, she answered: "Manufacturers do give higher discounts [i.e., payments] for exclusive [formulary] position . . . ." When asked why the PBM would not include both costly and lower-priced insulin medications on its formulary, Ms. Bricker stated plainly, "We'll receive less discount

in the event we do that."[117]

413. Dr. Dutta, Senior Vice President of OptumRx, stated that the cheaper list-priced alternative Admelog is not given preference on the formulary because "it would cost the payer more money to do that . . . [b]ecause the list price is not what the payer is paying. They are paying the net price."[118]

414. But payors do not pay the net price, even if rebates are passed through, because the PBMs receive and retain countless other forms of payments that drive up the gap between the list price and the net price retained by drug manufacturers. By giving preference to drugs with higher list prices based on the illusion of a lower net price, the PBMs are causing health plan payors and members to pay more while the PBMs keep greater profits for themselves. In other words, under the Insulin Pricing Scheme, PBMs and manufacturers can make a drug with a lower list price effectively more expensive for payors and then ostensibly save payors from that artificially

[117] Express Scripts' 2017 10-K states that "We maintain contractual relationships with numerous pharmaceutical manufacturers, which provide us with, among other things administrative fees for managing rebate programs, including the development and maintenance of formularies that include particular manufacturer's products . . . ." That is, the Manufacturers pay the PBMs to participate in the creation of formularies that payors are required to adopt as a condition for obtaining PBM services. Express Scripts Annual Report (Form 10-K) (FYE Dec. 31, 2017) at 24. It also notes that its business would be "adversely affected" if it were to "lose [its] relationship with one or more key pharmaceutical manufacturers." *Id.*

[118] *Priced Out of a Lifesaving Drug*, *supra* note 118, at 1394-95. As noted in the hearing, even the "cheaper" alternative Admelog "costs over $200 a bottle." *Id.* at 3121-26.

inflated price by giving preference to drugs that had higher list prices to begin with (yielding higher Manufacturer Payments to the PBMs).

415. On May 10, 2023, the U.S. Senate Committee on Health, Education, Labor, and Pensions held a hearing titled, "The Need to Make Insulin Affordable for All Americans."[119] At this hearing, the CEOs and presidents of the Manufacturer and PBM Defendants confirmed the substance of their testimony from 2019. David Ricks, for example, the Chair and CEO of Eli Lilly, testified that his company raised list prices and agreed to pay ever-increasing rebates to secure formulary placement:

> Getting on formulary is the best way to ensure most people can access our medicines affordably . . . . But that requires manufacturers to pay ever-increasing rebates and fees, which can place upward pressure on medicines' list prices. . . . Last year alone, to ensure our medicines were covered, Lilly paid more than $12 billion in rebates for all our medicines, and $1 billion in fees.[120]

416. Paul Hudson, the CEO of Sanofi, indicated that PBMs prefer drugs with higher list prices and that the manufacturers have responded accordingly. In discussing a drug Sanofi introduced with a lower list price, Hudson explained: "It just didn't get listed in any way. If price is really the motivator, it would have been listed."

417. While all Defendants acknowledged before Congress their participation

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[119] *The Need to Make Insulin Affordable for All Americans*, Hearing Before the S. Comm. on Health, Education, Labor & Pensions, 118th Cong. (May 10, 2023), available at https://www.help.senate.gov/hearings/the-need-to-make-insulin-affordable-for-all-americans (last visited Dec. 18, 2025).

[120] *Id. D. Ricks Testimony,* at 11.

in conduct integral to the Insulin Pricing Scheme, none revealed its inner workings or the connection between their coordination and the economic harm that payors, like Plaintiffs, and their Beneficiaries, were unwittingly suffering from. Instead, each Defendant group pointed the finger at the other as the party responsible for the price increases.

418. The PBM Defendants testified to Congress that the Manufacturer Defendants are solely responsible for their list price increases and that the Manufacturer Payments that the PBMs receive are not correlated to rising insulin prices. This is false. The amount the Manufacturers kick back to the PBM Defendants *is directly correlated* to an increase in list prices. On average, a $1 increase in Manufacturer Payments is associated with a $1.17 increase in list price.[121] Thus, reducing or eliminating Manufacturer Payments would lower prices and reduce out-of-pocket expenditures.

419. Further, in large part because of the increased list prices and related Manufacturer Payments, the PBMs' profit per prescription has grown substantially over the same period that insulin prices have steadily increased. For example, since 2003, Express Scripts has seen its profit per prescription increase more than 500%

[121] Neeraj Sood, *et al.*, *The Association Between Drug Rebates and List Prices*, USC Schaeffer Center for Health Policy and Economics (Feb. 11, 2020), *available at* https://schaeffer.usc.edu/research/the-association-between-drug-rebates-and-list-prices/ (last visited Dec. 152025).

per adjusted prescription.[122]

420. Novo Nordisk's President Doug Langa submitted written testimony to Congress in April 2019 acknowledging "there is no doubt that the WAC [list price] is a significant component" of "what patients ultimately pay at the pharmacy counter." Yet, the Manufacturers pressed the fiction that the PBMs were solely to blame for insulin prices because of their demands for rebates in exchange for formulary placement. The Manufacturers claimed their hands were tied and sought to conceal their misconduct by falsely suggesting that they have not profited from rising insulin prices.

421. Given the Manufacturers' claims that rebates were the sole reason for rising prices, each was asked directly during the Congressional hearing to guarantee it would decrease list prices if rebates were restricted or eliminated. The spokespersons for Eli Lilly, Novo Nordisk, and Sanofi all said only that they would "consider it."

422. In addition, a 2020 study from the Institute of New Economic Thinking titled "Profits, Innovation and Financialization in the Insulin Industry," demonstrates that during the time insulin price increases were at their steepest, distributions to the

[122] David Balto, *How PBMs Make the Drug Price Problem Worse*, THE HILL (Aug. 31, 2016, 5:51 p.m.), available at https://thehill.com/blogs/pundits-blog/healthcare/294025-how-pbms-make-the-drug-price-problem-worse (last visited Dec. 15, 2025).

Manufacturers' shareholders in the form of cash dividends and share repurchases totaled $122 billion. The Manufacturers actually spent a significantly lower proportion of profits on R&D during this time compared to shareholder payouts. The paper also notes that "[t]he mean price paid by patients for insulin in the United States almost tripled between 2002 and 2013" and that "per-person spending on insulin by patients and insurance plans in the United States doubled between 2012 and 2016, despite only a marginal increase in insulin use."[123]

423. The 2022 Community Oncology Alliance report found:[124]

> [T]here are several important ways that PBM rebates increase the costs of drugs for both plan sponsors and patients. . . . PBMs employ exceedingly vague and ambiguous contractual terms to recast monies received from manufacturers outside the traditional definition of rebates, which in most cases must be shared with plan sponsors. Rebate administration fees, *bona fide* service fees, and specialty pharmacy discounts/fees are all forms of money received by PBMs and rebate aggregators which may not be shared with (or even disclosed to) the plan sponsor. These charges serve to increase the overall costs of drugs, while providing no benefit whatsoever to plan sponsors. . . . The total drug spend of a plan sponsor, regardless of whether it is a federal or state governmental program or a self-funded employer, will inevitably increase because PBMs are incentivized to favor expensive drugs that yield high rebates. . . .

424. In January 2021, the Senate Finance Report detailed Congress's findings after reviewing more than 100,000 pages of internal company documents from

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[123] Rosie Collington, *Profits, Innovation and Financialization in the Insulin Industry*, Inst. For New Econ. Thinking (Apr. 2020), at 6, available at https://www.ineteconomics.org/uploads/papers/WP_120-Collington-The-insulin-industry.pdf (last visited Oct. 9, 2025).

[124] Community Oncology Alliance, *supra* note 106, at 17-18.

Sanofi, Novo Nordisk, Eli Lilly, CVS Caremark, Express Scripts, OptumRx, and Cigna. The report concluded, among other things:

- The Manufacturer Defendants retain more revenue from insulin than they did in the 2000s. For example, Eli Lilly has reported a steady increase in Humalog revenue for more than a decade—from $1.5 billion in 2007 to $3 billion in 2018.
- The Manufacturer Defendants have aggressively raised the list price of their insulin products absent significant advances in the efficacy of the drugs.
- The Manufacturer Defendants only spend a fraction of their revenue related to the at-issue drugs on research and development—Eli Lilly spent $395 million on R&D costs for Humalog, Humulin, and Basaglar between 2014-2018 during which time the company generated $22.4 billion in revenue on these drugs.

425. The truth is that, despite their finger-pointing in front of Congress, the Manufacturers and PBMs are both responsible for their concerted efforts in creating and effectuating the Insulin Pricing Scheme.

H. All Defendants Profit from the Insulin Pricing Scheme

426. The Insulin Pricing Scheme affords the Manufacturer Defendants the ability to pay the PBM Defendants exorbitant, yet secret, Manufacturer Payments in exchange for formulary placement, which garners the Manufacturer Defendants greater revenues from sales without decreasing their profit margins. During the relevant period, the PBM Defendants granted national formulary position to each at-issue drug in exchange for large Manufacturer Payments and inflated prices.

427. The Manufacturer Defendants also use the inflated price to earn hundreds

of millions of dollars in additional tax breaks by basing their deductions for donated insulins on the inflated list price.

428. Because of the increased list prices, and related Manufacturer Payments, the PBMs' profit per prescription has grown exponentially during the relevant period as well. A recent study published in the Journal of the American Medical Association concluded that the amount of money that goes to the PBM Defendants for each insulin prescription increased more than 150% from 2014 to 2018. In fact, for transactions in which the PBM Defendants control the PBM and the pharmacy (e.g., CVS Caremark-CVS pharmacy), these Defendants were capturing an astonishing 40% of the money spent on each insulin prescription (up from only 25% just four years earlier), even though they do not contribute to the development, manufacture, innovation, or production of the product.[125]

429. The PBM Defendants profit from the artificially inflated prices created by the Insulin Pricing Scheme in several ways, including by: (a) retaining a significant, yet undisclosed, percentage of the Manufacturers Payments, (b) using the inflated list price to generate profits from pharmacies, and (c) relying on the inflated list price to drive up the PBMs' margins through their own mail-order pharmacies.

1. *The PBMs Pocket a Substantial Share of Manufacturers' Secret Payments*

430. The first way in which the PBMs profit from the Insulin Pricing Scheme

[125] Van Nuys, *supra* note 99. .

is by keeping a significant portion of the secret Manufacturer Payments.

431. The amount that the Manufacturers pay the PBMs has increased over time both in real dollars and as a proportion of the ever-increasing list prices.

432. Historically, contracts between PBMs and payors allowed the PBMs to keep most or all of the rebates they received, rather than forwarding them to the payor.

433. Over time, payors secured contract provisions guaranteeing that PBMs would pay them all or some portion of the rebates that the Manufacturers paid to the PBMs. Critically, however, "rebates" are only one aspect of the total secret Manufacturer Payments, particularly as "rebates" are narrowly defined and qualified by vague exceptions in the PBM Defendants' contracts with payors.

434. Indeed, as described in the Senate Insulin Report, the PBMs and Manufacturers coordinate to determine the contract options made available to payors: "Contracts between PBMs and manufacturers provide a menu of options from which their health plan clients can choose certain terms and conditions."[126]

435. The contracts between the PBMs and Manufacturers also "stipulate terms the plans must follow regarding factors such as formulary placement and competition from other drugs in the therapeutic class."[127] Thus, the Manufacturers ultimately

[126] Senate Insulin Report *supra* note 7, at 40.

[127] *Id.* at 44.

played a role in dictating the terms and conditions of the contracts that payors like Plaintiffs entered into with PBMs. Of course, the payors were not involved in the coordination or the negotiation of the contracts between the PBMs and Manufacturers, and the PBMs disclosed only the fact that such relationships may exist. But the terms of the contracts, the consideration exchanged between the PBMs and Manufacturers, and the means of reaching these determinations all were—and remain—shrouded in secrecy.

436. The PBM and Manufacturer Defendants thus created a "hide-the-ball" system where payors like Plaintiffs are not privy to rebate negotiations or contracts between the Manufacturers and the PBMs. The consideration exchanged between them (and not shared with payors) is continually labeled and relabeled. As more payors moved to contracts that required PBMs to remit some or all manufacturer "rebates" through to the payor, the PBMs renamed the Manufacturer Payments to shield them from scrutiny and from their payment obligations.

437. Payments once called "rebates" in contracts with payors like Plaintiffs were then termed "administrative fees," "volume discounts," "service fees," "inflation fees," or other industry terms designed to obfuscate the substantial sums being secretly exchanged between the PBM Defendants and the Manufacturers.

438. In 2023, the Senate Commerce, Science and Transportation Committee released testimony from David Balto—a former antitrust attorney with the

Department of Justice and Policy Director for the Federal Trade Commission's Bureau of Competition—from a hearing on fairness and transparency in drug pricing. Mr. Balto's testimony describes how PBMs "transformed from 'honest brokers' supposedly negotiating with drug companies to obtain lower costs for insurers and patients into oligopolists using the rebates they extract from drug manufacturers and pharmacies to enrich themselves." He further testified:

> The PBM rebate system turns competition on its head with PBMs seeking higher, not lower prices to maximize rebates and profits. In the past decade, PBM profits have increased to $28 billion annually. . . . . PBMs establish tremendous roadblocks to prevent payors from knowing the amount of rebates they secure. Even sophisticated buyers are unable to secure specific drug by drug rebate information. PBMs prevent payors from being able to audit rebate information. As the Council of Economic Advisors observed, the PBM market lacks transparency as "[t]he size of manufacturer rebates and the percentage of the rebate passed on to health plans and patients are secret." Without adequate transparency, plan sponsors cannot determine if the PBMs are fully passing on any savings, or whether their formulary choices really benefit the plan and subscribers.[128]

439. The renamed, and secret, Manufacturer Payments are substantial. The use of "administrative fees" instead of "rebates" is one example. A heavily redacted complaint filed by Defendant Express Scripts in 2017 revealed that Express Scripts retains up to thirteen times more in "administrative fees" than it remits to payors in rebates. In fact, administrative fees can dwarf rebates. In just one alleged invoice

[128] David A. Balto, PBMs: The Middlemen Who Drive Up Drug Costs, Competition Policy International (May 31, 2022), https://www.competitionpolicyinternational.com/pbms-the-middlemen-who-drive-up-drug-costs/ (last visited Oct. 9, 2025)

Express Scripts was seeking payment for in that lawsuit, "administrative fees" were more than three-and-a-half times the amount billed for formulary rebates and price protection rebates *combined*.[129]

440. Although the proportion of rebates retained by PBMs remains a secret, commentators have suggested that PBMs "designate as much as twenty-five or thirty percent of the negotiated rebates as fees to avoid sharing the rebates."[130]

441. A review of Texas-mandated PBM disclosures also showed that PBMs retain a much greater percentage of manufacturer rebates than they lead on.[131] Under Texas law, certain PBMs are required to report "aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers." Between 2016 and 2021, the PBMs reported that they retained between 9% and 21% of total manufacturer payments.[132] Administrative fees, the report estimated, grew from $3.8 billion in 2018 to $5.8 billion in 2022.

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[129] *Express Scripts, Inc. v. Kaleo, Inc.*, No. 4:17-cv-01520-RLW (E.D. Mo. 2017); Balto, *supra* note 130.

[130] Joanna Shepherd, *Pharmacy Benefit Managers, Rebates, and Drug Prices: Conflicts of Interest in the Market for Prescription Drugs*, Yale Law & Policy Review, available at https://openyls.law.yale.edu/bitstream/handle/20.500.13051/17295/auto_convert.pdf?sequence=3&isAllowed=y (last visited Dec. 15, 2025).

[131] Adam Fein, *Texas Shows Us Where PBMs' Rebates Go*, Drug Channels (Aug. 9, 2022), https://www.drugchannels.net/2022/08/texas-shows-us-where-pbms-rebates-go.html (last visited Dec. 15, 2025).

[132] *Id.*

442. These so-called administrative fees typically are based on a percentage of the drug price—as opposed to a flat fee—such that even if the actual "administrative" cost associated with processing two drugs is the same, the "administrative fee" would be correspondingly higher for the higher-priced drug, which again creates (by design) a perverse incentive to give preference to more expensive drugs. Moreover, the PBM Defendants' contracts with payors narrowly define "rebates" by tying them to patient drug utilization. Thus, rebates for formulary placement (which are not tied to patient drug utilization) are characterized as "administrative fees" that are not remitted to payors. Such payments are beyond a payor's contractual audit rights because those rights are limited to "rebate" payments and these "administrative fees" have been carved out from the definition of "rebates."

443. The opaque nature of these arrangements between the Manufacturers and PBM Defendants also makes it impossible for a given payor to discover, much less assess or confront, conflicts of interest that may affect it or its members. The Senate Insulin Report observed with respect to these arrangements: "Relatively little is publicly known about these financial relationships and the impact they have on insulin costs borne by consumers."[133]

444. The PBMs have gone to great lengths to obscure these renamed Manufacturer Payments to avoid scrutiny from payors and others.

[133] Senate Insulin Report *supra* note 7, at 4.

445. For example, as to the Manufacturer Payments now known as "inflation fees," the PBMs often create a hidden gap between how much the Manufacturers pay them to increase their prices and the amount in "price protection guarantees" that the PBMs agree to pay back to their client payors.

446. The Manufacturer Defendants often pay the PBM Defendants "inflation fees" to increase the price of their diabetes medications. The thresholds for these payments are typically set at around 6% to 8%—if the Manufacturer Defendants raise their prices by more than the set percentage during a specified time period, then they pay the PBM Defendants an additional "inflation fee" (based on a percentage of the list prices).

447. For many of their clients, the PBMs have separate "price protection guarantees," providing that if the overall drug prices for that payor increase by more than a set amount, then the PBMs will remit a portion of the amount to the client.

448. The PBMs set these "price protection guarantees" at a higher rate than the thresholds that trigger the Manufacturers' "inflation fees," usually around 10%-15%.

449. Thus, if the Manufacturers increase their list prices more than the 6% (or 8%) inflation fee rate, but less than the 10%-15% client price protection guarantee rate, then the PBMs keep all of these "inflation fee" payments. This is a win-win for the Manufacturers and PBM Defendants—they share and retain the entire benefit of

these price increases while the PBM contracts with payors imply that payors are protected from price hikes by their price protection guarantees.

450. The PBM Defendants also hide the renamed Manufacturer Payments with "rebate aggregators." Rebate aggregators are also referred to as rebate group purchasing organizations, are entities that negotiate for and collect payments from drug manufacturers, including the Manufacturer Defendants, on behalf of a large group of PBMs (including the PBM Defendants) and different entities that contract for pharmaceutical drugs.

451. All PBM Defendants own or are closely affiliated with at least one rebate aggregator. As relevant here, Express Scripts established and controls Ascent; CVS Caremark established and controls Zinc; and OptumRx established and controls Emisar.

452. The PBMs established these GPOs between 2018 and 2021, in response to mounting pressure from payors to pass through more rebates and other payments collected from the Manufacturers and anticipated Congressional action that would have required more transparency from the PBMs.

453. To avoid passing these rebates and other payments through to payors, the PBMs adjusted their business models by adding rebate aggregators to the pharmaceutical payment chain.

454. As summarized by the recent Community Oncology Alliance report:[134]

> PBMs have increasingly "delegated" the collection of manufacturer rebates to "rebate aggregators," which are often owned by or affiliated with the PBMs, without seeking authorization from plan sponsors and without telling plan sponsors. . . . Even some of the major PBMs (i.e., the "Big Three" PBMs) sometimes find themselves contracting with other PBMs' rebate aggregators for the collection of manufacturer rebates. . . . In both the private sector and with respect to government health care programs, the contracts regarding manufacturer rebates (i.e., contracts between PBMs and rebate aggregators, as well as contracts between PBMs/rebate aggregators and pharmaceutical manufacturers) are not readily available to plan sponsors.

455. The rebate-aggregator GPOs perform the same contracting function that the PBMs once did themselves, such as negotiating with and collecting rebates from the Manufacturers. While they add no real value to the transactions they facilitate, the rebate aggregators retain a portion of the rebates they collect and impose additional fees on the Manufacturers, including new administrative and "data" fees, purportedly for their services.

456. Payors cannot trace these additional amounts, as they are negotiated and collected by the PBMs' affiliate-GPOs and not the PBM-entities that contract with payors. These amounts are not subject to audit, nor do the PBMs disclose the various "fees" the GPOs collect and retain to the SEC or elsewhere.

[134] Community Oncology Alliance, *supra* note 106.

457. Additionally, further impeding adequate oversight, certain rebate aggregators are located offshore, including Defendant Ascent, in Switzerland, and Defendant Emisar, which has significant operations in Ireland.

458. All told, the advent of rebate aggregators in the already complicated chain of financial transactions between drug manufacturers, pharmacy benefit managers, and payors creates an additional veil obfuscating the rebate payment trail and facilitates the PBMs' extraction of mislabeled rebates and additional fees from the Manufacturers without adding any value.

459. In an attempt to quantify the revenue PBMs receive from retained rebates, a 2023 report calculated PBM compensation from rebates and other kickbacks between 2018 and 2022 (the period during which rebate aggregators were introduced), and found that this compensation had *doubled*, from $3.8 billion to $7.6 billion.[135] "This growth was fueled by increases in traditional administrative fees as well as the emergence of new data and PBM contracting entity fees."[136] During the same period, "administrative fees" grew from $3.8 to $5.8 billion.[137]

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[135] Eric Percher, Trends in Profitability and Compensation of PBMs and PBM Contracting Entities, Nephron Research (Sept. 18, 2023) at 2, available at https://nephronresearch.bluematrix.com/sellside/AttachmentViewer.action?encrypt=1c65fc0e-f558-4f1d-891f-21c196a9f1ad&fileId=7276_04a77b17-d298-48a2-bd15-1c5ed22a6984&isPdf=false (last visited Dec. 15, 2025).

[136] *Id.*

[137] Fein, *supra* note 98.

460. And, as admitted by a former OptumRx executive who helped set up Emisar, OptumRx's rebate aggregator, "The intention of the G.P.O. [rebate aggregator] is to create a fee structure that can be retained and not passed on to a client."[138]

461. Before establishing Emisar, OptumRx worked with another rebate aggregator, the Coalition for Advanced Pharmacy Services, or "CAPS." CAPS is also a subsidiary of OptumRx, and ultimately of UnitedHealth Group.

462. A 2017 audit conducted by a local governmental entity on OptumRx related to its PBM activities from 2013 to 2015 was unable to verify the percentage of rebates OptumRx remitted to its client payor because OptumRx would not allow the auditor access to its rebate contracts. The audit report explained:

> Optum[Rx] has stated that it engaged the services of an aggregator to manage its rebate activity. Optum[Rx] shared that under this model, they are paid by their aggregator a certain amount per prescription referred. Then, the aggregator, through another entity, seeks rebates from the drug manufacturers, based upon the referred [Payor Client] prescription utilization, and retains any rebate amounts that may be received. Optum[Rx] states that they have paid [Payor Client] all amounts it has received from its aggregator, and that they do not have access to the contracts between the aggregator (and its contractors) and the manufacturer. However, our understanding is that Optum[Rx] has an affiliate relationship with its

[138] Rebecca Robbins & Reed Abelson, *The Opaque Industry Secretly Inflating Prices for Prescription Drugs*, N.Y. TIMES (June 21, 2024), available at https://www.nytimes.com/2024/06/21/business/prescription-drug-costs-pbm.html (last visited Dec. 15, 2025).

aggregator.[139]

463. A footnote in the audit report clarifies that "Optum[Rx] contracted with Coalition for Advanced Pharmacy Services (CAPS), and CAPS in turn contracted with Express Scripts, Inc. (ESI)."[140]

464. In other words, according to this report, OptumRx contracts with its own affiliate aggregator, CAPS, which then contracts with OptumRx's co-conspirator Express Scripts, which then contracts with the Manufacturers for rebates related to OptumRx's client's drug utilization. OptumRx then uses this complex relationship to mask the amount of Manufacturer Payments generated from its client's utilization.

465. A subsequent audit by the same local entity, covering the period September 2017 to September 2018, concluded:

> Several material weaknesses in Broward's agreement with Optum were identified, many of which are commonplace across pharmacy benefit manager agreements in general. Due to contract weaknesses, a comparison of Broward's PBM agreement, including rebate amounts received, to the Consultant's marketplace data is not feasible. Broward could save an estimated $1,480,000 per year in net prescription drug benefit expenses (based upon minimum rebate guarantees) by switching from its current flawed agreement with Optum, to an agreement with its Coalition, which offers clearly defined terms, increased rebate guarantees and cost saving

[139] Laura Rogers & Stacey Thomas, Broward County Pennsylvania, Audit of Pharmacy Benefit Management Services Agreement, No. 18-13 (Dec. 7, 2017), available at https://cragenda.broward.org/docs/2018/CCCM/20180109_555/25990_2017_1212%20Exh1_OptumRx%20-%20Revised%20Item.pdf (last visited Dec. 15, 2025).

[140] *Id.* at n.3.

requirements.[141]

466. Among other "loopholes" discovered in the contract were a number of "flawed" definitions, including (a) the definition of "Rebates," which "allows the exclusion of monies that should be included" and (b) limitations with respect to "Pass Through Transparency Pricing."

467. The January 2021 Senate Insulin Report summarized the Senate Finance Committee's findings from its two-year probe into the Insulin Pricing Scheme and contained the following observation on these rebate aggregators:

> [T]he recent partnership between Express Scripts and Prime Therapeutics may serve as a vehicle to avoid increasing legislative and regulatory scrutiny related to administrative fees by channeling such fees through a Swiss-based group purchasing organization (GPO), Ascent Health. While there are several regulatory and legislative efforts underway to prohibit manufacturers from paying administrative fees to PBMs, there is no such effort to change the GPO safe harbor rules. New arrangements used by PBMs to collect fees should be an area of continued investigative interest for Congress.[142]

468. Federal regulations governing Medicare attempt to capture all possible forms of Direct or Indirect Remuneration (DIR) to PBMs (and plan sponsors), defining the term as "any form of price concession" received by a plan sponsor or PBM "from any source," including "discounts, chargebacks, rebates, cash discounts,

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[141] Broward County, Florida, County Auditor's Office, Analysis of Broward County's Prescription Drug Coverage, Report No. 19-15 (Jul. 31, 2019), available at https://www.broward.org/Auditor/Reports/Reports/082019_Exh1_BCRxDrug_19-15.pdf (last visited Dec. 15, 2025).

[142] Senate Insulin Report *supra* note 7 at 83.

free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, legal judgment amounts, settlement amounts from lawsuits or other legal action, and other price concessions or similar benefits" and specifically including "price concessions from and additional contingent payments to network pharmacies that cannot reasonably be determined at the point of sale."[143]

469. The Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) considers all of the following as DIR: rebates, grants, reduced price administrative services, PBM-retained rebates, PBM rebate guarantee amounts, all post-point of sale payments by pharmacies that are not included in the negotiating price including dispensing incentive payments, prompt pay discounts, and payment adjustments. The following are not considered DIR: "bona fide service fees from pharmaceutical manufacturers" and "remuneration for administrative services with no impact on the sponsor's or PBM's drug cost (e.g., PBM incentive payments)" *but only to the extent they reflect fair market value for services rendered.*[144]

470. Because the PBM Defendants retain and conceal most of the non

[143] CMS, *Final Medicare Part D DIR Reporting Guidance for 2021* at 7, available at https://www.cms.gov/files/document/final2021dirreportingreqsmemo508v3.pdf (last visited Dec. 15, 2025).

[144] *Id.* at 6-7.

disclosed Manufacturer Payments that they receive, they reap exorbitant profits from the Insulin Pricing Scheme.

471. Even when payor clients receive a portion of the Manufacturer Payments from their PBM, the payors are significantly overcharged, given the extent to which Defendants have deceptively and egregiously inflated the prices of the at-issue drugs.

472. On September 20, 2024, the Federal Trade Commission brought suit against the PBM Defendants and their affiliated rebate aggregators for violations of Section 5 of the Federal Trade Commission Act "for engaging in anticompetitive and unfair rebating practices that have artificially inflated the list price of insulin drugs, impaired patients' access to lower list price products, and shifted the cost of high insulin list prices to vulnerable patients."

473. Specifically, the FTC Complaint revealed, among other things, (a) that the PBM Defendants' affiliated rebate aggregators "now perform the same commercial contracting function that the PBMs previously handled directly" and that the PBM Defendants "simply moved their commercial rebate contracting functions" to their affiliated rebate aggregators; (b) that the rebate aggregators solicit commercial bids from manufacturers using rebate grids "with different rebate rates for different levels of exclusivity: exclusive coverage (1 of 1 manufacturer), dual coverage with another manufacturer (1 of 2), and multiple manufacturers (1 of many)"; and (c) that the rebate aggregators extract WAC-based fees from drug

manufacturers as part of commercial negotiations but "provide no additional services to justify the higher payout on higher list price drugs from the assortment of WAC-based fees" the rebate aggregators extract from the manufacturers.

2. *The Insulin Pricing Scheme Allows the PBMs to Profit Off Pharmacies*

474. Another way the PBM Defendants profit off the Insulin Pricing Scheme is by using the Manufacturers' inflated price to derive profit from the pharmacies with whom they contract nationwide.

475. PBM Defendants decides which pharmacies are included in the PBM's network and how much it will reimburse these pharmacies for each drug dispensed.

476. The PBMs pocket the spread between the amount that the PBMs are paid by their clients, like Plaintiffs, for the at-issue drugs (which are based on the prices generated by the Insulin Pricing Scheme) and the amount the PBM reimburses the pharmacy (which is often less). In other words, the PBMs charge a client payor more for a drug than the PBM pays the pharmacy and pockets the difference.

477. More specifically, the PBM Defendants negotiate with their client payors a reimbursement rate that the client pays the PBM for each prescription drug dispensed by a pharmacy. The PBM Defendants negotiate a separate rate that they pay to pharmacies for each drug dispensed.

478. These rates are tied to AWP. For example, a PBM may purchase an insulin from the pharmacy at a rate of AWP-15%, and the client may reimburse the

PBM at a lower discount rate of AWP-13%. The PBM pockets the spread (2% of AWP in this example) between the rates.

479. Because the PBM Defendants' revenue from the spread pricing is tied to AWP, the higher the AWP, the greater the amount of money made by the PBMs. In the above example, if the AWP is $100 for a drug, the PBM would make $2 on the spread, but if the AWP is $1000 for the same drug, the PBM would make $20 on the spread from the same sale (AWP-15% = $850; AWP-13% = 870).

480. When a PBM is affiliated with a retail pharmacy, the PBM earns the entire retail margin in addition to the pricing spread described above.

481. The PBM Defendants, therefore, like the Manufacturers, directly benefit from inflated insulin prices.

482. In addition, because the PBM Defendants' client payors pay for thousands of different prescription drugs, the client payors cannot practically keep track of the AWP for each prescription drug on a given formulary or how those prices change over time. The client payors, therefore, are unlikely to independently observe the AWP inflation resulting from the Insulin Pricing Scheme. And the PBM Defendants have no incentive to alert their client payors to increasing AWPs since the PBM Defendants directly profit from those increases.

483. In addressing this form of spread pricing, the National Association of Insurance Commissioners states: "Pharmacy pricing is complex, and the process is

not transparent. Plan sponsors are often unaware of the difference between the amount they are billed and the pharmacy reimbursement."[145]

484. A bipartisan bill introduced in the Senate in 2022 (the Pharmacy Benefit Manager Transparency Act—S. 4293)—would have criminalized this practice of spread pricing, which the bill defined as "[c]harg[ing] a health plan or payer a different amount for a prescription drug's ingredient cost or dispensing fee than the amount the pharmacy benefit manager reimburses a pharmacy for the prescription drug's ingredient cost or dispensing fee where the pharmacy benefit manager retains the amount of any such difference." The bill has not yet been enacted.[146]

485. The PBMs' industry-funded trade association, PCMA, spent $7.8 million on lobbying in 2021, $8.66 million on lobbying in 2022, $15.43 million on lobbying in 2023, and $17.55 million on lobbying in 2024.[147]

486. The PBMs often disclose the general concept of spread pricing to payors, but only in vague terms that require no accountability. And because the spread-

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[145] NAIC, Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation—NAIC White Paper Draft as of April 16, 2023, available at: https://content.naic.org/sites/default/files/inline-files/NACDS%20Comments _0.pdf (last visited Dec. 15, 2025).

[146] *See* S. 127, Pharmacy Benefit Manager Transparency Act of 2023, 118th Cong. (2023) (bill introduced Jan. 26, 2023), https://www.govtrack.us/congress/bills/118/s127 (last visited Dec. 15, 2025).

[147] OpenSecrets, *Client Profile: Pharmaceutical Care Management Ass'n Annual Lobbying Totals*, https://www.opensecrets.org/orgs/pharmaceutical-care-management-assn/lobbying?id=D000028342 (last visited Dec. 15, 2025).

pricing revenue is not defined as a "rebate" in PBM contracts with payors, it falls outside payors' audit rights.

487. This spread pricing, like the secret Manufacturer Payment negotiation, happens behind closed doors. There is no transparency, no commitment from the PBM Defendants to consider the cost-effectiveness of a drug, and no communication to either the payor or the pharmacy to let them know if they are getting a fair deal.

488. The higher the Manufacturers' list prices, the more money the PBMs make off the spread. At the same time, a Beneficiary's out-of-pocket co-pay or deductible cost often is more than if the client had simply paid cash outside of his or her plan. On top of this, the PBM contracts generally allow no rebates to payors where the Beneficiary is responsible for 100% of the drug cost, e.g., under his or her deductible.

489. The PBM Defendants also use the Insulin Pricing Scheme to generate additional profits from pharmacies by charging the pharmacies post-purchase fees, including DIR (Direct or Indirect Remuneration) fees, based on the list prices—and again, the higher the list price for each diabetes medication sold, the greater the fees the PBMs generate. They also apply "retrospective" discounts so, for example, a payor's (and member's co-pay or deductible) cost may be $100, but the price may be discounted post-purchase between the PBM and the (often self-owned) pharmacy to $90, with the spread going to the PBM.

490. The Centers for Medicare & Medicaid Services (CMS) addressed these and similar DIR issues in a proposed rule in 2017. While noting the growth of "pharmacy price concessions" that "are negotiated between pharmacies and their sponsors or PBMs," CMS nevertheless concluded:

> When manufacturer rebates and pharmacy price concessions are not reflected in the price of a drug at the point of sale, beneficiaries might see lower premiums, but they do not benefit through a reduction in the amount they must pay in cost-sharing, and thus, end up paying a larger share of the actual cost of a drug. Moreover, given the increase in manufacturer rebates and pharmacy price concessions in recent years, the point-of-sale price of a drug that a Part D sponsor reports on a PDE record as the negotiated price is rendered less transparent . . . .[148]

CMS expressed further concern that when rebates and other price concessions are not reflected in the negotiated point-of-sale drug price, it "can impede beneficiary access to necessary medications, which leads to poorer health outcomes and higher medical care costs for beneficiaries . . . ."[149]

491. So, the PBM Defendants make money "coming and going." In a pre-PBM world, a competitively priced drug might have a (hypothetical) net cost to a health plan of $50, and that is what it paid. Now, the PBMs coordinate with Manufacturers to increase the list price to $150. The PBMs then "negotiate" the

[148] Medicare Program; Contract Year 2019 Policy and Technical Changes, 82 Fed. Reg. 56336 (Nov. 29, 2017), at 56419, https://www.govinfo.gov/content/pkg/FR-2017-11-28/pdf/2017-25068.pdf (last visited Dec. 15, 2025).

[149] *Id.*

inflated price down to $100 and take a $50 rebate, some of which may be forwarded to the payor, whose net cost is less than the inflated list price, but whose real-world cost is considerably more than if the PBMs were not involved.

492. At the same time, the PBMs receive "administrative fees" for including certain drugs on its formularies, which are not considered "rebates." The PBMs also receive "service fees" or other payment for "administrative services" provided to the Manufacturers such as "formulary compliance initiatives," "education services," or the sale of non-patient identifiable claim information. These revenue streams are outside the typical definition of "rebates" found in contracts between the PBM Defendants and payors.

493. The PBMs then charge payors administrative fees for providing pharmacy benefit management services and charges for drug costs (a/k/a ingredient costs) and per-prescription dispensing fees, as well as additional administrative fees for services not included in the PBMs' general administrative obligations. The PBMs then receive rebates and/or discounts (pre-purchase or post-purchase) from the pharmacies, which the PBMs often own. These too are excluded from the definition of "rebates." These and other revenue streams are sometimes disclosed, but only in hazy, overly generalized terms. And they are beyond a payor's contractual rights to audit for "transparency" purposes because they are not defined "rebates."

494. Additionally, the PBMs may take months to pay rebates to payors and

the PBMs retain all interest on, and the time-value of, the rebates pending payment. This is one example of a PBM "disclosure" excerpted from a payor's PBM contract with Express Scripts:

> This disclosure provides an *overview* of the *principal* revenue sources of Express Scripts, Inc. and Medco Health Solutions, Inc. (individually and collectively referred to herein as "ESI"), as well as ESI's affiliates. In addition to administrative and dispensing fees paid to ESI by our clients for pharmaceutical benefit management ("PBM") services, ESI and its affiliates derive revenue from other sources, including arrangements with pharmaceutical manufacturers, wholesale distributors, and retail pharmacies. *Some* of this revenue relates to utilization of prescription drugs by members of the clients receiving PBM services. ESI *may* pass through certain manufacturer payments to its clients or *may* retain those payments for itself, depending on the contract terms between ESI and the client. . . . Formulary rebate amounts vary based on the volume of utilization as well as formulary position applicable to the drug or supplies, and adherence to *various* formulary management controls, benefit design requirements, claims volume, and *other similar factors*, and *in certain instances* also *may* vary based on the product's market-share. ESI *often* pays an amount equal to all or a portion of the formulary rebates it receives to a client based on the client's PBM agreement terms. ESI retains the financial benefit of the use of any funds held until payment of formulary rebate amounts is made to the client. In addition, ESI provides administrative services to formulary rebate contracted manufacturers, which include, *for example*, maintenance and operation of the systems and other infrastructure necessary for managing and administering the PBM formulary rebate process and access to drug utilization data, as allowed by law, for purposes of verifying and evaluating the rebate payments and for other purposes related to the manufacturer's products. ESI receives administrative fees from the participating manufacturers for these services. (emphasis added)

495. Payors have no access to, and no knowledge of, the intricacies of the dealings between the PBM Defendants and the Manufacturers that are shrouded by such vague "disclosures" (which vary in detail, but not in substance, in all three of

the PBM Defendants' adhesive contracts). These disclosures could be summed up in a single sentence: "We pass along 'rebates' to client payors, except when we don't."

3. *The Insulin Pricing Scheme Increases PBM Mail-Order Profits*

496. Another way the PBM Defendants profit from the Insulin Pricing Scheme is through their mail-order pharmacies. The higher the price that PBM Defendants can get customers, such as Plaintiffs, to pay for diabetes medications, the greater the profits PBM Defendants realize through their mail-order pharmacies.

497. Because the PBM Defendants base the prices they charge for the at-issue diabetes medications on the Manufacturers' prices, the more the Manufacturers inflate their prices, the more money PBMs make.

498. When PBM Defendants have their own mail-order pharmacies, their profits are even greater than when they are dispensed through its retail network pharmacies because they capture the entire retail margin as increased by the Insulin Pricing Scheme.

499. As a result of their collusion with the Manufacturers, the PBMs often know when the Manufacturers are going to raise their prices and use that to their advantage. Specifically, the PBMs purchase a significant volume of the at-issue drugs before the price increase goes into effect. Then, after the Manufacturers raise their price, the PBMs charge their mail-order customers based on the increased prices and pocket the difference. The PBMs make significant amounts of money through this

arbitrage scheme.

500. The PBMs also charge the Manufacturer Defendants fees related to their mail-order pharmacies, such as pharmacy supplemental discount fees, that are directly tied to the Manufacturers' price. Once again, the higher the price is, the more money the PBMs make on these fees.

501. In sum, each way in which the PBM Defendants make money on diabetes medications is tied directly to their coordination with the Manufacturers to establish artificially higher prices and induce ever-increasing secret Manufacturer Payments. Contrary to their representations, the PBM Defendants are not lowering the price of diabetes medications. Instead, they are working with the Defendant Manufacturers to make billions of dollars at the expense of payor clients and their beneficiaries by fueling these skyrocketing prices.

I. Plaintiffs Purchased The At-Issue Drugs Directly from Defendants

502. As large employers and healthcare providers, Plaintiffs serve their community by providing public life-saving medical services, comprehensive treatments, and other vital public health services. Plaintiffs have a growing list of priorities on a limited budget, so any significant increase in spending can have a severe detrimental effect on Plaintiffs' overall budget and, in turn, negatively impact their abilities to provide life changing health and research services to the community.

503. One benefit Plaintiffs provide the Beneficiaries is payment for a large

portion of their pharmaceutical purchases. In this role, Plaintiffs have spent significant amounts on the at-issue diabetes medications during the relevant period.

504. Because Plaintiffs maintain a self-funded plan, they do not rely on a third-party insurer to pay for their insured's medical care, pharmaceutical benefits, or prescription drugs. Rather, Plaintiffs contracted directly and/or through an agent with PBMs (and their affiliated pharmacies) for pharmaceutical benefits and prescription drugs, including the at-issue medications.

505. In the context of Plaintiffs' purchases of the at-issue medications, Plaintiffs and its Beneficiaries are the victims of the Insulin Pricing Scheme. Plaintiffs are the only named parties that paid and continue to pay the full purchase price for the at-issue drugs, and the only named party that have not knowingly participated in the Insulin Pricing Scheme. Neither the PBM Defendants nor the Manufacturer Defendants—who benefitted from the Insulin Pricing Scheme—suffered or suffer losses from the Insulin Pricing Scheme.

506. As part of purchasing the at-issue drugs from the PBMs, Plaintiffs contracted with the PBMs and consequently were forced to pay artificially inflated costs resulting from the Insulin Pricing Scheme, including "administrative fees," "inflation fees," "discounts," and more—all of which are associated with Plaintiffs' purchase of the at-issue drugs. Because the at-issue drugs are potentially life-saving medications, and because the Manufacturers control the market for these drugs,

Plaintiffs have no choice but to pay these exorbitant, artificially inflated prices directly to the PBM Defendants.

507. Plaintiffs also relies (and has relied) on the PBMs as administrative agents for the purported purposes of limiting their administrative burden and controlling pharmaceutical drugs costs during the relevant period. These PBM services included, but were not limited to, developing and offering formularies for Plaintiffs' prescription plan, constructing and managing Plaintiffs' pharmacy network (which included the PBMs' retail and mail-order pharmacies), processing pharmacy claims, and providing mail-order pharmacy services to Plaintiffs.

508. In providing PBM services to Plaintiffs, the prices set by Defendants as part of the Insulin Pricing Scheme were artificially inflated, and Plaintiffs paid Defendants directly and/or through their agents for the at-issue drugs.

J. Defendants Deceived Plaintiffs

509. At no time has either Defendant group disclosed the Insulin Pricing Scheme or the artificially inflated list prices produced by it.

510. At all times during the relevant period, the Manufacturer Defendants knew that the list prices, net prices, and payors' net costs (purchase prices) generated by the Insulin Pricing Scheme were artificially inflated, excessive, and untethered to any legal, competitive, or fair market price.

511. The Manufacturer Defendants knew that these prices did not bear any

rational relationship to the actual costs incurred or prices realized by Defendants, did not result from transparent or competitive market forces, and were artificially and arbitrarily inflated for the sole purpose of generating profits for Defendants.

512. The insulin market, and Defendants' business arrangement relating to it, exhibit the key features of oligopolies—the concentration of numerous competitors into a small group of firms that dominates the market, high barriers to entry, ability to set and control prices, firm interdependence, and maximal revenues.

513. The Manufacturer Defendants also knew that payors, including Plaintiffs, relied on the artificially inflated list prices generated by the Insulin Pricing Scheme to pay for the at-issue drugs.

514. The Manufacturer and PBM Defendants further knew that Plaintiffs—like any reasonable consumers and particularly ones with fiduciary obligations to their Beneficiaries—intended and expected to pay a price reflecting the lowest fair market value for the drugs (which was not necessarily the same as the lowest price in the market, as all prices were inflated due to the Insulin Pricing Scheme).

515. Despite this knowledge, the Manufacturer Defendants published the prices generated by the Insulin Pricing Scheme throughout the United States and Pennsylvania in publishing compendia, in various promotional and marketing materials distributed by entities downstream in the drug supply chain, and directly to pharmacies, which then used these prices to set the amount that the pharmacies

charged for the at-issue drugs.

516. The Manufacturer Defendants also published these prices to the PBMs and pharmacies, which then used them to charge diabetics and payors like Plaintiffs for the at-issue drugs.

517. By publishing their prices throughout Pennsylvania and in other states, the Manufacturer Defendants held each of these prices out as a reasonable price on which to base the prices that payors actually pay for the at-issue drugs.

518. These representations are false. The Manufacturer Defendants knew that their artificially inflated list prices were not remotely related to their cost, their fair market value in a competitive market, or the net price received for the at-issue drugs.

519. During the relevant period, the Manufacturer Defendants published prices in Pennsylvania and other states at hundreds of dollars per dose for the same at-issue drugs that would have been profitable to them at prices less than $10 per dose.

520. The Manufacturer Defendants also have publicly represented that they price the at-issue drugs according to each drug's value to the health care system and the need to fund innovation. During the relevant period, executives from Lilly, Sanofi and Novo Nordisk falsely represented that research and development costs were key factors driving the at-issue price increases.[150]

[150] Drug Pricing Investigation, *supra* note 39, at pp. 166-172.

521. To the contrary, between 2005 and 2018, Eli Lilly spent $680 million on R&D costs related to Humalog while earning $31.35 billion in *net* sales during that same period. In other words, Eli Lilly made more than 46 times its reported R&D costs on Humalog during this portion of the relevant period, i.e., R&D costs amounted to a fraction of net sales. Novo Nordisk has spent several times the amount it spends on R&D on stock buyouts and shareholder dividend payouts in recent years.[151]

522. The January 2021 Senate Insulin Report found that the PBMs consider insulins to be "interchangeable" from "a clinical perspective" and that Manufacturers "focus their R&D efforts on new insulin-related devices, equipment, and other mechanical parts that are separate from insulin's formulation."[152]

523. A House Oversight Committee staff report concluded that "drug companies' claims that reducing U.S. prescription drug prices will harm innovation is overblown" and that "[m]any drug companies spent a significant portion of their R&D budget on finding ways to suppress generic and biosimilar competition while continuing to raise prices, rather than on innovative research."[153]

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[151] *Id.*

[152] *See* Senate Insulin Report, *supra* note 7, at p. 43.

[153] Drug Pricing Investigation: Industry Spending on Buybacks, Dividends and Executive Compensation, H.R. Comm. on Oversight and Reform, 117th Cong. (July 2021) at 2, available at https://oversightdemocrats.house.gov/sites/evo-

524. In sum, the Manufacturer Defendants affirmatively withheld the truth from Plaintiffs and specifically made misrepresentations in furtherance of the Insulin Pricing Scheme and to induce Plaintiffs' reliance to purchase the at-issue drugs.

525. The PBM Defendants ensured that the Manufacturer Defendants' artificially inflated list prices harmed diabetics and payors by selecting at-issue drugs with the highest prices for preferred formulary placement and by requiring that their contracts with both pharmacies and with payors include such prices as the basis for payment.

526. The PBM Defendants perpetuate the use of the artificially inflated insulin prices because it allows them to obscure the actual price any entity in the drug pricing chain is paying for the at-issue drugs. This lack of transparency affords Defendants the opportunity to construct and perpetuate the Insulin Pricing Scheme and to profit at the expense of Pennsylvania and nationwide payors.

527. At all times throughout the relevant period, the PBMs have purposefully, consistently, and routinely misrepresented that they negotiate with Manufacturer Defendants and construct formularies for the benefit of payors and patients by lowering the price of the at-issue drugs and by promoting the health of diabetics. Representative examples include:

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subsites/democrats-oversight.house.gov/files/COR%20Staff%20Report%20-%20Pharmaceutical%20Industry%20Buybacks%20Dividends%20Compared%20to%20Research.pdf (last visited Dec. 15, 2025).

- Defendant CVS Caremark has, for the past decade, stated in its annual reports that its design and administration of formularies are aimed at reducing the costs and improving the safety, effectiveness, and convenience of prescription drugs. CVS Caremark has further stated that it maintains an independent panel of doctors, pharmacists, and other medical experts to review and approve the selection of drugs based on safety and efficacy for inclusion on one of CVS Caremark's template formularies and that CVS Caremark's formularies lower the cost of drugs.[154]

- Defendant Express Scripts has consistently represented that it works with clients, manufacturers, pharmacists, and physicians to increase efficiency in the drug distribution chain, to manage costs in the pharmacy benefit chain and to improve members' health outcomes. Its annual reports consistently claim that in making formulary recommendations, Express Scripts' Pharmacy & Therapeutics Committee considers the drug's safety and efficacy, without any information on or consideration of the cost of the drug, including any discount or rebate arrangement that Express Scripts negotiates with the Manufacturer, and that Express Scripts fully complies with the P&T Committee's clinical recommendations regarding drugs that must be included or excluded from the formulary based on their assessment of safety and efficacy.[155]

- Defendant OptumRx has consistently stated in its annual reports over the past decade that OptumRx's rebate contracting and formulary management assist customers in achieving a low-cost, high-quality pharmacy benefit. It has consistently claimed that it promotes lower costs by using formulary programs to produce better unit costs, encouraging patients to use drugs that offer improved value and that OptumRx's formularies are selected for health plans based on their safety, cost, and effectiveness.[156]

528. In addition to these general misrepresentations, the PBM Defendants

[154] *See, e.g.*, CVS Health Annual Reports (Form 10-K) (FYE 2010-2019).

[155] *See, e.g.*, Express Scripts Annual Reports (Form 10-K) (FYE 2010-2019).

[156] *See, e.g.*, OptumRx Annual Reports (Form 10-K) (FYE 2010-2019).

have, during the relevant period, purposefully, consistently, and routinely made misrepresentations about the at-issue diabetes medications. Representative examples include:

- In a public statement issued in May 2010, CVS Caremark represented that it was focused on diabetes to "enhance diabetes patients' interaction with their pharmacists as a way to improve health outcomes and rein in the cost of care=. . . a PBM client with 50,000 employees whose population has an average prevalence of diabetes could save approximately $3.3 million a year in medical expenditures."[157]

- In a public statement issued in November 2012, CVS Caremark represented that formulary decisions related to insulin products "is one way the company helps manage costs for clients."[158]

- In 2016, Glen Stettin, Senior Vice President and Chief Innovation Officer at Express Scripts, said in an interview with a national publication that "[d]iabetes is wreaking havoc on patients, and it is also a runaway driver of costs for payors . . . [Express Scripts] helps our clients and diabetes patients prevail over cost and care challenges created by this terrible disease."[159] Mr. Stettin also claimed that Express Scripts "broaden[s] insulin options for patients and bend[s] down the cost curve of what is currently the costliest class of traditional prescription

[157] Chain Drug Review, *CVS Expands Extracare for Diabetes Products* (May 11, 2010), available at https://www.chaindrugreview.com/cvs-expands-extracare-for-diabetes-products/ (last visited Dec. 15, 2025).

[158] Jon Kamp & Peter Loftus, *CVS' PBM Business Names Drugs It Plans to Block Next Year*, WALL ST. J. (Nov. 8, 2012), available at http://online.wsj.com/article/SB10001424127887324439804578107040729812454.html (last visited Dec. 15, 2025).

[159] Angela Mueller, *Express Scripts Launches Program to Control Diabetes Costs*, ST. LOUIS BUS. J. (Aug. 31, 2016), available at https://www.bizjournals.com/stlouis/news/2016/08/31/express-scripts-launches-program-to-control.html (last visited Dec. 15, 2025).

drugs."[160]

- In 2017, Express Scripts' CEO, discussing a program involving insulin, "disputed the idea that Express Scripts contributes to rising drug costs."[161]

- In a 2018 Healthline interview, Mark Merritt, long the President of the PBM trade association, PCMA, misrepresented that through their formulary construction: "PBMs are putting pressure on drug companies to reduce insulin prices."[162]

- CVS Caremark's Chief Policy and External Affairs Officer claimed in the April 2019 hearings that CVS Caremark "has taken a number of steps to address the impact of insulin price increases. We negotiate the best possible discounts off the manufacturers' price on behalf of employers, unions, government programs, and beneficiaries that we serve."[163]

- Dr. Sumit Dutta, SVP and Chief Medical Officer of OptumRx, testified before the U.S. Congress in the April 2019 hearing that for "insulin products . . . we negotiate with brand manufacturers to obtain significant

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[160] Express Scripts, PR NEWSWIRE, *Express scripts Launches Diabetes Care Value Program[SM], Guaranteeing More Affordable, High-Quality Diabetes Care*, Aug. 23, 2016, available at https://www.prnewswire.com/news-releases/express-scripts-launches-diabetes-care-value-program-guaranteeing-more-affordable-higher-quality-diabetes-care-300320485.html#:~:text=The%20new%20program%20%E2%80%93%20part%20of,anticipated%20increase%20in%20diabetes%2Ddrug (last visited Dec. 15, 2025).

[161] Katie Thomas, *Express Scripts to Offer Cheaper Drugs for Uninsured Customers*, N.Y. TIMES, May 8, 2017, available at https://www.nytimes.com/2017/05/08/health/express-scripts-drug-prescriptions-prices.html (last visited Dec. 15, 2025).

[162] Dave Muoio, *Insulin Prices: Are PBMs and Insurers Doing Their Part?*, Population Health Learning Network (Dec. 2016), available at https://www.hmpgloballearningnetwork. com/site/frmc/article/insulin-prices-are-pbms-and-insurers-doing-their-part (last visited Dec. 15, 2025).

[163] Priced Out of a Lifesaving Drug, *supra* note 118, at 715-718.

discounts off list prices on behalf of our customers."[164]

- In May 2023, OptumRX's CEO, Heather Cianfrocco, told the U.S. Senate Committee on Health, Education, Labor, and Pensions that OptumRx "has been at the forefront of efforts to improve access to affordable insulin and provide comprehensive care to patients with diabetes."[165]

529. The PBM Defendants not only falsely represent that they negotiate with the Manufacturer Defendants to lower the prices of the at-issue diabetes medications for payors, but also for diabetic patients as well. Representative examples include:

- Express Scripts' code of conduct, effective beginning in 2015, states: "At Express Scripts we're dedicated to keeping our promises to *patients and clients* . . . This commitment defines our culture, and all our collective efforts are focused on our mission to make the use of prescription drugs safer and more affordable."[166]

- Amy Bricker—former President of Express Scripts and PCMA board member—testified before Congress in April 2019: "At Express Scripts we negotiate lower drug prices with drug companies on behalf of our clients, *generating savings that are returned to patients* in the form of lower premiums and reduced out-of-pocket costs."[167]

- Ms. Bricker also testified that "Express Scripts remains committed to . . . *patients* with diabetes and creating affordable access to their

[164] *Id*. at 903-06.

[165] Heather Cianfrocco Written Testimony, *The Need to Make Insulin Affordable for All Americans* (May 10, 2023), at 5 available at https://www.help.senate.gov/imo/media/doc/Cianfrocco%20Written%20Testimony%20HELP%20Committee%20_Final.pdf (last visited Dec. 15, 2025).

[166] Express Scripts, *Code of Conduct*, at 2, https://www.express-scripts.com/aboutus/codeconduct/ExpressScriptsCodeOfConduct.pdf (last visited Dec. 15, 2025).

[167] Priced Out of a Lifesaving Drug, *supra* note 118 at 803-06.

medications."[168]

- OptumRx CEO John Prince testified to the Senate: "We *reduce the costs of prescription drugs* [and] we are leading the way to ensure that *those discounts directly benefit consumers*. . . OptumRx's pharmacy care services business is *achieving better health outcomes for patients, lowering costs* for the system, and *improving the healthcare experience for consumers*. . . OptumRx negotiates better prices with drug manufacturers *for our customers and for consumers*.[169]

- In its 2017 Drug Report, CVS Caremark stated that the goal of its pharmacy benefit plans is to ensure "that the cost of a drug is aligned with the value it delivers in terms of *patient* outcomes . . . [I]n 2018, we are doing even more to help keep drugs affordable with our new Savings *Patients* Money initiative."[170]

- The PCMA website touts PBMs as "the only entity in the prescription drug supply and payment chain dedicated to reducing drug costs" and (contradicting the PBM representatives' Congressional testimony), that "when new manufacturers enter the market at a lower list price, PBMs use the competition to drive costs down."[171]

530. Not only have the PBM Defendants intentionally misrepresented that

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[168] *Id*. at lines 838-40.

[169] Drug Pricing in America: A Prescription for Change, Part III, hearing before the S. Comm. on Finance, 116th Cong., 1st Sess., Apr. 9, 2019, S. Hrg. 116-415, at 170-171, available at https://www.finance.senate.gov/imo/media/doc/435631.pdf

(last visited Oct. 9, 2025) (hereinafter "Drug Pricing in America").

[170] *See*, CVS Health, *CVS Health Kept Drug Price Growth Nearly Flat and Improved Medication Adherence for PBM Clients in 2017* (Apr. 5, 2018), available at https://www.cvshealth.com/news/pharmacy/cvs-health-kept-drug-price-growth-nearly-flat-and-improved.html (last visited Oct. 9, 2025).

[171] PCMA, *PBMs Reduce Insulin Costs: PBMs are working to improve the lives of patients living with diabetes and their families,* available at https://www.pcmanet.org/insulin-managing-costs-with-increasing-manufacturer-prices/ (last visited Dec. 15, 2025).

they use their market power to save payors money, but they have also specifically and falsely disavowed that their conduct drives prices higher. Some examples include:

- On an Express Scripts' earnings call in February 2017, CEO Tim Wentworth stated: "Drugmakers set prices, and we exist to bring those prices down."[172]
- Larry Merlo, head of CVS Caremark sounded a similar refrain in February 2017: "Any suggestion that PBMs are causing prices to rise is simply erroneous."[173]
- In 2017, Express Scripts' Wentworth went on CBS News to argue that PBMs play no role in rising drug prices, stating that PBMs work to "negotiate with drug companies to get the prices down."[174]
- During the April 2019 Congressional hearings, when asked if PBM-negotiated rebates and discounts were causing the insulin price to increase, OptumRx's Chief Medical Officer Sumit Dutta answered, "we can't see a correlation just when rebates raise list prices."[175]
- In 2019, when testifying Congress on the rising price of insulins, Amy

[172] Samantha Liss, *Express Scripts CEO Addresses Drug Pricing 'Misinformation'*, St. Louis Post-Dispatch (Feb. 17, 2017), available at https://www.stltoday.com/business/local/ express-scripts-ceo-addresses-drug-pricing-misinformation/article_8c65cf2a-96ef-5575-8b5c-95601ac51840.html (last visited Dec. 15, 2025).

[173] Lynn R. Webster, *Who Is To Blame For Skyrocketing Drug Prices?*, THE HILL (July 27, 2017, 11:40 AM), available at https://thehill.com/blogs/pundits-blog/healthcare/344115-who-is-to-blame-for-skyrocketing-drug-prices (last visited Dec 15, 2025).

[174] CBS News, *Express Scripts CEO Tim Wentworth Defends Role of PBMs in Drug Prices* (Feb. 7, 2017), available at https://www.cbsnews.com/news/express-scripts-tim-wentworth-pbm-rising-drug-prices-mylan-epipen-heather-bresh/ (last visited Dec. 15, 2025).

[175] Priced Out of a Lifesaving Drug, *supra* note 118, at 1021-22.

> Bricker—then with Express Scripts, now with CVS—testified, "I have no idea why the prices [for insulin] are so high, and it's not the fault of rebates."[176]

531. All of Defendants' public statements regarding insulin pricing have been consistent with the misrepresentations above and those detailed below. None have contradicted those misrepresentations or revealed the Insulin Pricing Scheme.

532. Although Plaintiffs' employees responsible for managing Plaintiffs' health plans were not following the various Congressional hearings when they occurred and were not exposed to all misrepresentations detailed above (or all of those detailed below), the public pronouncements by Defendants were consistent with those misrepresentations.

533. Plaintiffs' interactions, directly and/or through its agents, with the PBMs were consistent with those misrepresentations, which were made in furtherance of, and in order to conceal, the Insulin Pricing Scheme.

534. In both the period preceding and following those Congressional hearings—of which Plaintiffs were unaware—Plaintiffs repeatedly inquired, directly and/or through its agents, how rebates were calculated, and Defendants uniformly represented that rebates were fully passed through and did not reflect inflated costs, while refusing to disclose the methodology used to calculate those rebates and instead shrouding that information in secrecy.

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[176] *Id.*, at 1016-17.

535. While bombarding Plaintiffs and / or its agent, consumers, and the public with misrepresentations and half-truths like those above, none of the PBMs revealed the details of their relationships with the Manufacturer Defendants or the existence of the Insulin Pricing Scheme.

536. Never did any of the PBMs, disclose that they actually *benefit* from higher list prices for the at-issue drugs and would be *discouraging* competition on list prices behind the scenes.

537. Throughout the relevant period, the PBM Defendants have consistently and repeatedly represented that: (a) their interests are aligned with their payor clients; (b) they work to lower the price of the at-issue drugs and, in doing so, achieve substantial savings for diabetics and payors; and (c) that monies they receive from manufacturers and their formulary choices are for the benefit of payors and diabetics.

538. Indeed, the PBM Defendants have promised to avoid conflicts of interest. For example, the PCMA has Principles of Professional and Ethical Conduct to which all PCMA members, including the three PBM Defendants, have agreed.[177] This code of ethics requires the PBM Defendants to "[a]void any and all conflicts of interest and advise all parties . . . of any situations where a conflict of

[177] *Principles of Professional and Ethical Conduct*, PCMA, available at https://www.pcma.org/about/principles-of-professional-and-ethical-conduct/ (last visited Dec. 15, 2025).

interest exists."[178]

539. PBM Defendants also publish codes of conduct requiring employees and entities to avoid conflicts of interest.[179] Despite these obligations, the PBM Defendants have substantial pecuniary interests that conflict with their duties to Plaintiffs. The PBM Defendants artificially inflate the price of insulin for their profit, to the detriment of payors, including Plaintiffs, directly and through through theiragents.

540. The PBM Defendants understand that payors like Plaintiffs rely on the PBMs to achieve the lowest prices for the at-issue drugs and to construct formularies designed to improve access to medications, and Plaintiffs did rely on them. Indeed, Express Scripts' CEO told the U.S. Senate that PBMs "exist to help solve the challenge[]" of rising drug prices, including insulin, by "negotiating with large pharmaceutical manufacturers to lower the cost of drugs for employers, health plans, federal and state governments, and most importantly, patients."[180]

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[178] *Id.*

[179] Code of Conduct, Express Scripts, *supra* note 169; Code of Conduct, CVS Caremark, available at https://media.corporate-ir.net/media_files/irol/99/99533/corpgov/codeofconduct03.pdf (last visited Dec. 15, 2025); Code of Conduct, UnitedHealth Group, available at https://professionals.optumrx.com/content/dam/optum3/professional-optumrx/resources/FWA_CoCs_2018.pdf (last visited Dec. 15, 2025).

[180] Adam Kautzner, *The Need to Make Insulin Affordable for All Americans*, Testimony Before the U.S. S. Comm. on Health, Educ., Labor, and Pensions, (May

541. Throughout the relevant period, the PBM Defendants also falsely claimed they are transparent about the Manufacturer Payments and that the amounts they remit (or not) to payors. In fact, the PBM Defendants' disclosures of their ties to the Manufacturer Defendants were vague, equivocal, and misleading. Their manner of defining "rebates" in payor contracts was illusory and subject to indeterminable conditions and exceptions. The PBM Defendants thereby facilitated and obtained secret Manufacturer Payments far above and beyond the amounts of "rebates" remitted to payors.

542. The PBM Defendants' internal processes and accounting were and are abstruse and opaque, allowing them to overtly mislead the public and payors like Plaintiffs.

543. For example, in 2011, OptumRx's President stated: "We want our clients to fully understand our pricing structure . . . Every day we strive to show our commitment to our clients, and one element of that commitment is to be open and honest about our pricing structure."[181]

10, 2023) at 2, available at https://www.help.senate.gov/imo/media/doc/Kautzner%20Express%20Scripts%20HELP%20Hearing%20Testimony%2005102023.pdf (last visited Dec. 15, 2025).

[181] UnitedHealth Group, *Prescription Solutions by OptumRx Receives 4th Consecutive TIPPS Certification for Pharmacy Benefits Transparency Standards* (Sept. 13, 2011), available at https://web.archive.org/web/20210805182422/https://www.unitedhealthgroup.com/newsroom/2011/0913tipps.html (last visited Dec. 15, 2025).

544. When testifying before the Senate Finance Committee, CVS Executive Vice President Derica Rice stated, "[A]s it pertains to transparency overall, we at CVS Caremark are very supportive. We provide full visibility to our clients of all our contracts and the discounts that we negotiate on their behalf. . . And transparency—today we report and fully disclose not only to our clients, but to CMS [Medicare]."[182]

545. At the same hearing, Steve Miller of Cigna (Express Scripts) testified: "we are really a strong proponent for transparency for those who pay for health care. So the patient should know exactly what they are going to pay. Our plan sponsors need to know exactly what is in their contract."[183]

546. John Prince of OptumRx stated: "Senator, if our discounts were publicly available, it would hurt our ability to negotiate effectively. Our discounts are transparent to our clients."[184]

547. When testifying before Congress in April 2019, Amy Bricker, then a Senior Vice President of Defendant Express Scripts, claimed transparency with payors and echoed Mr. Prince's need for confidentiality around discounts:[185]

> Ms. Bricker. The rebate system is 100 percent transparent to the plan sponsors and the customers that we service. To the people that hire us, employers of America, the government, health plans, what we negotiate for them is transparent to them. . . The reason I'm able to get the

[182] Drug Pricing in America, *supra* note 172, at 28, 32.

[183] *Id.* at 32.

[184] *Id.*

[185] Priced Out of a Lifesaving Drug, *supra* note 118, at 2469-96.

> discounts that I can from the manufacturer is because it's confidential [to the public].
>
> ***
>
> Mr. Sarbanes. Yeah, because it is a secret. What about if we made it completely transparent? Who would be for that?
>
> ***
>
> Ms. Bricker. Absolutely not . . . . It will hurt the consumer. . . because . . . prices will be held high.

548. Consistent with the PBM Defendants' intention in creating these rebate aggregators "to create a fee structure that can be retained and not passed on to a client,"[186] the PBM Defendants also intentionally withhold information about their use of affiliated rebate aggregators (like Defendants Zinc, Ascent, and Emisar) to negotiate and collect rebates and additional fees from the Manufacturers. The PBMs use these GPOs to obfuscate the payment trail of rebates and these additional "fees," which are promised to payors under their sponsor agreements with the PBMs. The PBM Defendants do not disclose the amounts collected by or details about the rebate aggregators in their SEC filings, nor do they disclose their existence or activity to payors publicly, in sponsor agreements or RFP responses, or in other communications. These amounts are also not subject to audit because they are not classified as rebates collected by the PBMs.

549. As recently as May 2022, JC Scott—President of the PBM trade group

[186] Robbins & Abelson, *supra* note 140.

PCMA—testified before the Senate Commerce Committee:[187]

> PBMs are proud of the work they do to reduce prescription drug costs, expand affordable access to medications, and improve patient outcomes. PBMs negotiate with drug companies to lower prescription drug costs PBMs advocate for patients in the fight to keep prescription drugs accessible and affordable.

550. Mirroring the PCMA website, Mr. Scott also testified, "The PBM industry is the only stakeholder in the chain dedicated to seeking lower costs."[188]

551. During the relevant period, as seen above, PBM Defendants represented to payors, including Plaintiffs, that they constructed formularies and negotiated with the Manufacturer Defendants for the benefit of payors and patients to maximize drug cost savings while promoting the health of diabetics.

552. Throughout the relevant period, the PBMs made the foregoing and similar misrepresentations consistently and directly to Pennsylvania payors, including Plaintiffs, through bid proposals, member communications, invoices, formulary change notifications, and through extensive direct-to-consumer pull through efforts engaged in with the Manufacturers.

553. All such representations are false. The Manufacturer and PBM

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[187] Juan Carlos "JC" Scott, President & CEO, Pharm. Care Mgmt. Ass'n, Testimony Before the S. Subcomm. on Consumer Prot. Prod. Safety, & Data Sec. of the S. Comm. on Commerce, Sci., & Transp., 117th Cong. (May 5, 2022) at 2, available at https://www.commerce.senate.gov/services/files/61891DE9-AB7F-4325-97C3-531B4C0C8D7B (last visited Dec. 15, 2025).

[188] *Id.* at 3.

Defendants in fact coordinated to publish the artificially inflated prices and to construct the PBM formularies, causing the price of the at-issue drugs to skyrocket. For example:

- In 2018, the United States spent $28 billion on insulin compared with $484 million in Canada. The average American insulin user spent $3490 on insulin in 2018 compared with $725 among Canadians.[189]
- Diabetics who receive their medications from federal programs that do not use the PBMs also pay significantly less. For example, in December 2021, the United States House of Representatives Committee on Oversight and Reform issued its Drug Pricing Investigation Report finding that federal health care programs that negotiate directly with the Manufacturers (like the Department of Veterans Affairs), and are thus outside the PBM Defendants' scheme, paid $16.7 billion less from 2011 through 2017 for the at-issue drugs than the Medicare Part D program, which relies on the PBM Defendants to set their at-issue drug prices (and are thus victims of the PBMs' concerted efforts to drive up list prices).

554. Defendants knew that their representations were false when they made them and coordinated to withhold the truth from payors, including Plaintiffs.

555. Defendants concealed the falsity of their representations by closely guarding their pricing negotiations, structures, agreements, sales figures, and the flow of money and other consideration between them.

556. The Defendants have never revealed the full amount of any drug-specific Manufacturer Payments exchanged between them.

557. The PBM Defendants do not disclose the terms of their agreements with

[189] Trevor Schneider et al., Comparisons of Insulin Spending and Price Between Canada and the United States, 97 *Mayo Clinic Proceedings*, 573–578 (2022).

the Manufacturers or the Manufacturer Payments they receive. Nor do they disclose the details related to their agreements (formal or otherwise) with pharmacies. All those revenue streams are beyond the scope of the payors' contractual audit rights.

558. Further, although PBMs negotiate drug-specific rebates with Manufacturers, the PBM rebate payments to payor clients and summaries of such payments are in the aggregate, rather than on a drug-by-drug basis. It is impossible for payors like Plaintiffs to tease out drug-specific rebates, much less the other undisclosed Manufacturer Payments. This allowed the PBM Defendants to hide the large Manufacturer Payments that they receive for the at-issue diabetes medications.

559. The PBM Defendants have gone so far as to sue governmental entities to block the release of details on their pricing agreements with the Manufacturers and pharmacies.

560. Even when audited by payors, the PBM Defendants routinely refuse to disclose their agreements with the Manufacturers and pharmacies, relying on overly broad confidential agreements and claims of trade secrets and by erecting other unnecessary roadblocks and restrictions.

561. Beneficiaries of Plaintiffs' health plans have no choice but to pay prices flowing from the Manufacturers' inflated list prices because Beneficiaries need these medications to survive and the Manufacturer Defendants produce virtually all diabetes medications available in the United States. The list prices generated by the

Defendants' coordinated efforts directly impact out-of-pocket costs at the point of sale.

562. In sum, the entire insulin pricing structure created by Defendants—from the artificially inflated prices to the Manufacturers' misrepresentations related to the reasons behind the prices, to the inclusion of the false prices in payor contracts, to the non-transparent Manufacturer Payments, to the misuse of formularies, to the PBMs' representations that they work to lower prices and promote the health of diabetics—is unconscionable, deceptive, and immensely lucrative for Defendants.

563. Plaintiffs did not know, because Defendants affirmatively concealed, that: (a) the Manufacturers and PBMs coordinated to create the PBM formularies in exchange for money and other consideration; (b) the list prices were falsely inflated; (c) the list prices were manipulated to satisfy PBM profit demands; (d) the list prices and net costs (purchase prices) paid by Plaintiffs bore no relationship to the fair market value of the drugs themselves or the services rendered by the PBMs in coordinating their pricing; or (e) the entire insulin pricing structure Defendants created was false.

K. The Insulin Pricing Scheme Has Damaged Plaintiffs

564. Plaintiffs provides health and pharmacy benefits to its Beneficiaries, including employees, retirees, and their dependents.

565. One benefit Plaintiffs provide to the Beneficiaries of their healthcare

plan is paying for their pharmaceutical needs.

566. Plaintiffs were unaware of the Insulin Pricing Scheme during the relevant time period. Plaintiffs relied on Defendants' public statements and material omissions.

567. Plaintiffs contracted with various PBMs for PBM services.

568. Defendants' Insulin Pricing Scheme has cost Plaintiffs millions of dollars in overcharges.

569. Indeed, since 2011, Plaintiffs have spent millions on the at-issue diabetes medications.

570. Defendants failed to adhere to principles of good faith and fair dealing in carrying out their PBM contracts with Plaintiffs. Defendants' respective relationships with Plaintiffs were inherently unbalanced and their contracts adhesive. Defendants had superior bargaining power and superior knowledge of their relationships with the Manufacturer Defendants, including those that ultimately dictated the drug costs Plaintiffs incurred. Although Defendants were supplying a vital service, they exploited their superior positions to mislead Plaintiffs and thwart their expectations, all at great expense to Plaintiffs. Defendants' misrepresentations, omissions, and misconduct—including and as manifested in the Insulin Pricing Scheme—directly and proximately caused economic damage to Plaintiffs as a payor/purchaser of Defendants' at-issue diabetes medications.

571. A substantial proportion of the money Plaintiffs spent on diabetes medications is attributable to Defendants' inflated prices, which did not arise from competitive market forces but, instead, exist solely because of the Insulin Pricing Scheme.

572. Because of Defendants' success in concealing the Insulin Pricing Scheme through act and omission, no payor, including Plaintiffs, knew or should have known during the relevant period that the prices for the at-issue diabetes medications were and are artificially inflated due to the Insulin Pricing Scheme.

573. As a result, Plaintiffs have unknowingly overpaid for the Manufacturer Defendants' diabetes medications, which would have cost less but for the Insulin Pricing Scheme.

574. In addition, because of the inflated AWPs caused by the Insulin Pricing Scheme, Plaintiffs' Beneficiaries had greater out-of-pocket expenses (because their co-pays are tied to AWP). As a result, those Beneficiaries reached their annual spending caps sooner, and Plaintiff were obligated to pay more for those Beneficiaries to cover the remainder of the plan year.

575. In short, the Insulin Pricing Scheme has directly and proximately caused Plaintiff to substantially overpay for diabetes medications.

576. Because Defendants continue to generate exorbitant, unfair, and deceptive prices for the at-issue drugs through the Insulin Pricing Scheme, the harm

to Plaintiffs is ongoing.

L. Defendants' Recent Efforts in Response to Rising Insulin Prices

577. In reaction to mounting political and public outcry, Defendants have taken action on both Capitol Hill and in the public relations space.

578. First, in response to public criticism, Defendants have increased their spending to spread their influence in Washington D.C.

579. For example, in recent years Novo Nordisk's political action committee ("PAC") has doubled its spending on federal campaign donations and lobbying efforts. In 2017 alone, Novo Nordisk spent $3.2 million lobbying Congress and federal agencies, its biggest ever investment in directly influencing U.S. policymakers. Eli Lilly and Sanofi also have contributed millions of dollars through their PACs in recent years.

580. Second, Defendants have recently begun publicizing programs ostensibly aimed at lowering the cost of insulins.

581. These affordability measures do not address the structural issues that caused the price hikes. Rather, these are public relations measures that do not solve the problem.

582. For example, in March 2019, Defendant Eli Lilly announced that it would produce an authorized generic version of Humalog, "Insulin Lispro," and promised that it would "work quickly with supply chain partners to make [the

authorized generic] available in pharmacies as quickly as possible."

583. At the time, Eli Lilly told the Senate Finance Committee that "we can provide a lower-priced insulin more quickly without disrupting access to branded Humalog, on which thousands of insured patients depend and which will remain available for people who want to continue accessing it through their current insurance plans."[190]

584. When it launched Lispro, its press release said the drug was the "same molecule" as Humalog, yet would be sold at half the price of Humalog. Eli Lilly expressly said it was to help make insulin medications "more affordable."[191]

585. However, in the months after Eli Lilly's announcement, reports raised questions about the availability of "Insulin Lispro" in local pharmacies.

586. Following this, the staff of the Offices of U.S. Senators Elizabeth Warren and Richard Blumenthal prepared a report examining the availability of this drug.

587. The investigative report, *Inaccessible Insulin: The Broken Promise of Eli Lilly's Authorized Generic*, concluded that Eli Lilly's lower-priced, authorized generic insulin is widely unavailable in pharmacies across the country, and that the

[190] Joseph B. Kelly, Letter to S. Fin. Comm. (Mar. 8, 2019), available at https://www.finance.senate.gov/imo/media/doc/Eli%20Lilly_Redacted%20v1.pdf. (last visited Dec. 15, 2025).

[191] Eli Lilly and Co., March 4, 2019, Press Release, *Lilly to Introduce Lower-Priced Insulin*, available at https://investor.lilly.com/node/40881/pdf (last visited Dec. 15, 2025).

company has not taken meaningful steps to increase insulin accessibility and affordability.[192]

588. In 2019, Novo Nordisk partnered with Walmart to offer ReliOn brand insulins for a discounted price at Walmart. However, experts have warned that the Walmart/Novo Nordisk insulins are not substitutes for most diabetics' regular insulins and should only be used in an emergency or when traveling. In particular, for many diabetics, especially Type 1 diabetics, these insulins can be dangerous. In any event, ReliOn is not included on any of the PBM Defendants' formularies as of January 2023.

589. Thus, Defendants' "lower priced" insulin campaigns have not addressed the problem and the PBMs continue to exclude drugs with lower list prices despite their assurances of cost-savings for payors and Beneficiaries.

590. Plaintiffs continue to suffer harm caused by the Insulin Pricing Scheme.

V. ACCRUAL AND TOLLING OF THE STATUTES OF LIMITATION

591. Plaintiffs' claims are timely under multiple accrual doctrines – including the discovery rule, the separate accrual rule, and the continuing violation doctrine – under which Defendants bear the burden of proving untimeliness. In the alternative,

[192] Sen. Elizabeth Warren & Sen. Richard Blumenthal, *Inaccessible Insulin: The Broken Promise of Eli Lilly's Authorized Generic*, (Dec. 2019), available at https://www.warren.senate.gov/imo/media/doc/Inaccessible%20Insulin%20report.pdf (last visited Dec. 15, 2025).

and to the extent necessary, Plaintiffs also pleads tolling doctrines such as fraudulent concealment, equitable estoppel, and *American Pipe* tolling, all of which further support the timeliness of Plaintiffs' claims.

A. Discovery Rule

592. Plaintiffs have diligently pursued and investigated the claims herein. Plaintiffs did not discover the existence of its injuries or the factual basis for its claims and wrongful conduct causing them until shortly before filing this Complaint and, through the exercise of reasonable diligence, could not have discovered them until a date within the applicable statute of limitations period.

593. Plaintiffs exercised reasonable diligence under the circumstances but was unable to discover the wrongful nature of Defendants' conduct or the resulting injury. The complexity and opacity of the insulin pricing system—including confidential rebate structures, undisclosed formulary placement terms, and non-public financial arrangements—prevented Plaintiffs from learning the material facts necessary to assert its claims.

594. Plaintiffs were unaware of its economic injury or that this injury was caused by Defendants, nor did it have reason to suspect it until a date within the applicable statute of limitations. To the contrary, Plaintiffs were affirmatively led off the trail by Defendants statements, omissions, and conduct, which concealed the existence and nature of their evolving scheme and secretive agreements in a complex

industry in which natural price increases might be reasonably expected by payors such as Plaintiffs.

595. Defendants labeled critical information as proprietary or trade secret, shielded it behind sweeping confidentiality agreements, and contractually limited payor audit rights—all of which they used as subterfuge to refuse to disclose material information, including rebate and fee structures and financial arrangements between PBMs and Manufacturers. These tactics effectively prevented Plaintiffs from obtaining the information necessary to uncover the existence, scope, illegality, and evolving nature of the Insulin Pricing Scheme.

596. Defendants used these secrecy mechanisms—along with the inherent complexity of the pharmaceutical pricing and reimbursement system—to affirmatively prevent Plaintiffs from accessing information necessary to detect the scheme or understand the nature and extent of their injuries. These practices were not incidental; they were designed and maintained to keep purchasers like Plaintiffs unaware of the coordinated and unlawful conduct between and among the Defendants.

597. Each Defendant group also affirmatively disavowed wrongdoing and falsely claimed that their dealings with payors like Plaintiffs were honest and transparent.

598. To the extent Defendants claim there were any warnings or disclosures

regarding their conduct, those purported warnings were rendered ineffective by the evolving nature of the scheme, which was deliberately structured to obscure its true character and avoid detection, including, but not limited to, through disavowals of wrongdoing and the improper use of intellectual property and confidentiality claims to shroud the scheme from scrutiny.

599. Further, some of the PBM Defendants' rebate aggregators—specifically Zinc Health Services, Ascent Health Services, and Emisar Pharma Services—were not established until dates within the applicable statute of limitations period, or, alternatively, were entities whose existence and involvement in the Defendants' scheme Plaintiffs did not and could not reasonably have discovered until recently.

600. These rebate aggregators were created to negotiate and collect rebates and other fees from Manufacturers on behalf of the PBM Defendants. Their formation marked a material evolution in Defendants' scheme to conceal rebate flows, obscure financial relationships, and extract additional profits from payors such as Plaintiffs.

601. The creation and use of these rebate aggregators, who operated in secrecy, further impeded Plaintiffs' ability, through the exercise of reasonable diligence, to discover the true nature and scope of Defendants' wrongful conduct. The aggregators were deliberately structured to add another layer of opacity between PBMs and Manufacturers, allowing Defendants to claim that rebates were

"passed through" while retaining substantial sums as aggregator "fees."

602. Even today, lack of transparency in the pricing of diabetes medications and the arrangements, relationships, and agreements between and among the Manufacturer Defendants and the PBM Defendants, i.e., the Insulin Pricing Scheme, continue to obscure Defendants' unlawful conduct from Plaintiffs and the general public.

603. For these reasons, Plaintiffs' claims are within the applicable statute of limitations under the discovery rule.

B. Separate Accrual Rule and Continuing Violations

604. Plaintiffs' claims are timely under the well-established separate accrual and/or continuous violation rule, because Defendants have engaged in a continuing pattern of unlawful conduct that caused Plaintiffs to suffer new and independent injuries cause by new predicate or overt acts within the applicable limitations' periods.

605. The acts, omissions, and misrepresentations alleged throughout this Complaint – including Defendants' scheme centered on inflating and maintaining artificially high insulin prices through coordinate conduct – is ongoing and has continued to the present day. Defendants' systematic misconduct constitutes a continuous violation of the law that has caused, and continues to cause, continuous economic harm to Plaintiffs.

606. Defendants' scheme did not remain static. Over time, Defendants evolved and adjusted their conduct in ways that both perpetuated and concealed the scheme, and gave rise to new predicate or overt acts, including, but not limit to, through changes in pricing structures, rebate arrangements, formulary placement strategies, and contracting practices.

607. These changes were designed not only to continue extracting inflated payments from Plaintiffs, but also to obscure the nature of the misconduct, prevent meaningful public scrutiny, and frustrate detection by Congress, payers, and other stakeholders.

608. Within the applicable statute of limitations prior to filing this Complaint, Defendants altered their strategies in ways that masked their ongoing misconduct. Rather than abandoning the scheme, they adopted new mechanisms impeding the ability of Plaintiffs to identify continuing misconduct, helping Defendants avoid detection and accountability, and giving rise to new predicate and overt acts that injured Plaintiffs.

609. These new and independent predicate or overt acts included, but is not limited to, entering into separate contracts and rebate arrangements, executing new formulary changes, and implementing pricing and reimbursement strategies that caused Plaintiffs to incur distinct injuries.

610. Plaintiffs also entered into and operated under separate contracts and

reimbursement obligations, reflecting a separate and discrete transaction, during the relevant statutory periods. Defendants' conduct under these separate agreements gave rise to new predicate or overt acts with separate injuries.

611. The establishment and operation of the PBM Defendants' rebate aggregators began in 2019 (Ascent) and continued in 2020 (Zinc) and 2022 (Emisar)[193] represent new predicate and overt acts within the applicable limitations period that caused Plaintiffs new and independent injuries.

612. Through these rebate aggregators, Defendants materially evolved the Insulin Pricing Scheme by outsourcing rebate negotiations to PBM-owned subsidiaries, often located outside the United States, which imposed additional "aggregator fees" before passing any remaining rebate amounts to the PBMs or plan sponsors.

613. These new mechanisms enabled Defendants to further distort pricing, obscure rebate flows, and falsely represent to Congress, regulators, and payors that PBMs were "passing through" nearly all manufacturer rebates, when in reality

[193] FTC Deepens Inquiry into Prescription Drug Middlemen, Fed. Trade Comm'n (May 17, 2023), available at https://www.ftc.gov/news-events/news/press-releases/2023/05/ftc-deepens-inquiry-prescription-drug-middlemen (last visited Dec. 15, 2025); Adam J. Fein, *Five (or Maybe Six?) Reasons That the Largest PBMs Operate Group Purchasing Organizations*, **Drug Channels** (May 24, 2023), https://www.drugchannels.net/2023/05/five-or-maybe-six-reasons-that-largest.html (last visited Dec. 15, 2025).

substantial sums were siphoned off through aggregator charges.

614. The ongoing use of the rebate aggregators constitute new and independent predicate or overt acts that inflicted distinct economic injuries on Plaintiffs within the limitations period, including payments distorted by undisclosed aggregator fees and concealed pricing structure.

615. Plaintiffs suffered new and independent injuries within the limitations periods as a direct result of these distinct predicate or overt acts, including payments made at artificially inflated prices and distorted formulary placements.

616. The predicate acts occurring within the applicable limitations' periods caused injuries that were separable from, and not merely a continuation of, any prior injury that may have occurred outside the statutory window.

617. Accordingly, Plaintiffs' claims fall within and accrued during the applicable limitations period.

C. Class Action Tolling

618. Plaintiffs' claims are based on the same conduct alleged in a class action lawsuit against the same Defendants and involving the same claims, and therefore relate back to that date for purposes of any statute of limitations defenses.

619. Plaintiffs were included in the defined class in the Class Action complaint.

620. Under the tolling rule articulated in *Am. Pipe & Const. Co. v. Utah*, 414

U.S. 538 (1974) ("*American Pipe*") the filing of a class action lawsuit in federal court tolls the statute of limitations for the claims of unnamed class members until the class certification issue is resolved.

621. Plaintiffs reasonably and justifiably relied on the named Plaintiffs in the Class Action and the class action tolling doctrine in *American Pipe.*

622. Although the classes in the Class Action have not been certified yet and Plaintiffs' claims are related to those covered and based on the conduct as in the Class Action, Plaintiffs have chosen to file this separate action to assert its claims which have been tolled during the pendency of the Class Action.

623. Accordingly, Plaintiffs' claims are timely pursuant to the class action tolling doctrine endorsed in *American Pipe* and subsequent decisions.

D. Fraudulent Concealment

624. Through the acts, omissions, and misrepresentations alleged throughout this Complaint, Defendants fraudulently concealed the fact of Plaintiffs' economic injury and its cause.

625. Defendants cannot rely upon any statute-of-limitations defense because they purposefully concealed the Insulin Pricing Scheme, their generation of false list prices, the creation and use of PBM-affiliated rebate aggregators, and the fact that the prices for the at-issue diabetes medications were artificially inflated. The Defendants

deliberately concealed their behavior and active role in the Insulin Pricing Scheme, the mechanisms of their evolving scheme, and other unlawful conduct.

626. Defendants' acts, omissions, and misrepresentations —including those relating to the establishment and operation of their rebate aggregators— were calculated to, and did, lull and induce payors, including Plaintiffs, into forgoing legal action or any inquiry that might lead to legal action. Defendants' acts, omissions, and representations were intended to and, in fact, did prevent Plaintiffs from discovering its claims.

627. Defendants knowingly and fraudulently concealed the facts alleged herein. Defendants knew of the wrongful acts set forth above, had information pertinent to their discovery, and concealed them from the public, including Plaintiffs. As a result of Defendants' conduct, Plaintiffs did not know, and could not have known through the exercise of reasonable diligence, of the existence or scope of the Insulin Pricing Scheme, including the use of rebate aggregator entities, some of which are located outside of the United States to obscure fees and rebate flows, or of Plaintiffs' causes of action.

628. Defendants continually and secretly engaged in the Insulin Pricing Scheme. Only Defendants and their agents knew or could have known about Defendants' unlawful actions because Defendants made deliberate efforts to conceal their conduct, including by interposing affiliated rebate aggregators such as Zinc,

Ascent, and Emisar to shield the true flow of fees and manufacturer rebates. As a result of the above, Plaintiffs were unable to obtain vital information bearing on its claims absent any fault or lack of diligence on its part.

629. As alleged herein, and among other things, Defendants affirmatively concealed: (a) that the Manufacturers and PBMs coordinated to create the PBM formularies in exchange for money and other consideration; (b) that the list prices were falsely inflated and manipulated; (c) that the list prices and net costs (purchase prices) paid by payors and patients bore no relationship to the fair market value of the drugs themselves or the services rendered by the PBMs in coordinating their pricing; (d) that the at-issue insulin drugs were selected for inclusion or preferred status on the formularies based on higher prices (and greater potential revenues for Defendants) rather than because of cost-effectiveness or because they were beneficial to payors' Beneficiaries; (e) the exchange of various payments and pricing agreements between the Manufacturers and PBMs; (f) that the entire insulin pricing structure Defendants created was false; and (g) that PBM Defendants had established affiliated rebate aggregators to receive, process, and retain portions of manufacturer rebates under the guise of "aggregator fees," thereby concealing the true nature and magnitude of payments received.

630. As alleged more fully herein, the PBM Defendants have blocked drug pricing transparency efforts, including but not limited to, by structuring rebates, fees

and transactions through rebate aggregators that are not subject to public reporting, regulatory scrutiny, or SEC disclosure requirements. In fact, is it only since Utah adopted a bill (effective in early 2025) that requires health insurers to make sure their PBMs either pass the rebate on to the consumer at the point of sale, use the rebates to reduce premiums of the enrollee, or increase benefits for the enrollee, that some of these tactics have come to light.[194]

631. As alleged more fully herein, the Manufacturer Defendants have testified to Congress that they were not responsible for skyrocketing insulin prices, claiming that they had no control over the pricing, blaming the PBM Defendants for the high prices, and suggesting that they have not profited from astronomical insulin prices.

632. Meanwhile, the PBM Defendants testified to Congress that the Manufacturer Defendants were solely responsible for the list price increases and that the payments that the PBMs receive from the Manufacturer Defendants are unrelated to rising insulin prices, all while concealing the existence and role of their affiliated rebate aggregators.

[194] H.B. 0257, Pharmacy Benefit Amendments (Utah 2025), https://le.utah.gov/~2025/bills/static/HB0257.html

(last visited Dec. 15, 2025); Brian Nowosielski, Dae Lee, & Lucas Morgan, Pass-Through Rebate Law Uncovering New PBM Tactics, Entities, Drug Topics (Oct. 28, 2025), https://www.drugtopics.com/view/pass-through-rebate-law-uncovering-new-pbm-tactics-entities-ncpa-2025

(last visited Dec. 15, 2025).

633. As alleged herein, the PBM Defendants concealed the Insulin Pricing Scheme through vague and manipulable definitions of terms in their contracts, including by hiding the fees that the Manufacturer Defendants paid to the PBM Defendants and which the PBM Defendants retained and did not pass along to payors as Rebates.

634. The PBM Defendants also concealed payments they received from the Manufacturer Defendants and others through their affiliated rebate aggregators, hiding them in complex contractual relationships—often with other Defendants—and not reporting them in their quarterly SEC filings. The use of these rebate aggregators allowed PBM Defendants to falsely represent that nearly all rebates were "passed through" to payors while diverting substantial sums through undisclosed aggregator fees.

635. Defendants coordinated to affirmatively withhold the truth about the Insulin Pricing Scheme from payors, including Plaintiffs, patients, and the public and concealed the falsity of representations made to payors, including Plaintiffs, by closely guarding their pricing negotiations, structures, agreements, sales figures, and the flow of money and other consideration between them including those funneled through rebate aggregators.

636. Plaintiffs did not know, and could not reasonably have discovered, the full extent of agreements between the PBM Defendants and the Manufacturer

Defendants or payments the Manufacturer Defendants and their rebate aggregators, or payments made through those entities, because Defendants actively concealed these agreements and payments.

637. Despite the claims of transparency made to payors, including Plaintiffs, and to the public, Defendants have never revealed the full amount of drug-specific payments they have exchanged or received, including those routed through rebate aggregators. Payors, including Plaintiffs, and patients reasonably relied on Defendants' claims of transparency.

638. Defendants intended that their actions and omissions would be relied upon by the public, to include payors and patients. Plaintiffs did not know, and did not have the means to know, the truth due to Defendants' actions and omissions.

639. Plaintiffs reasonably relied on Defendants' affirmative statements to Congress and the public that Defendants were working to lower insulin prices and provide payors with cost savings, unaware that Defendants were simultaneously using rebate aggregators to perpetuate and conceal inflated pricing.

640. The purposes of the statute of limitations are satisfied because Defendants cannot claim any prejudice due to an alleged late filing where the Plaintiffs filed suit promptly upon discovering the facts essential to its claims, described herein, which Defendants knowingly concealed.

641. In light of the information set forth above, it is clear that Defendants had

actual or constructive knowledge that their conduct was deceptive, in that they consciously concealed the schemes set forth herein, including the use of rebate aggregators to obscure rebate and pricing information.

642. Any applicable statutes of limitation therefore have been tolled.

E. Equitable Estoppel

643. Defendants were under a continuous duty to disclose to Plaintiffs the true character, quality, and nature of the prices upon which payments for diabetes medications were based, the true nature of the services being provided and the existence and role of affiliated rebate aggregators—all of which would be and are now material to Plaintiffs.

644. Instead of disclosing these facts, Defendants knowingly misrepresented and concealed them, including by structuring transactions through their affiliated rebate aggregators, with a reasonable expectation that Plaintiffs would act upon the misrepresentations and omissions.

645. Being unaware of the true facts and the economic harm it was suffering and having no cause to inquire further due to Defendants' misrepresentations and concealment of its evolving scheme, including the rebate aggregators' role.

646. Though Defendants' acts, omissions, and misrepresentations as alleged throughout this Complaint, Defendants knowingly misrepresented and concealed material facts with the expectation that Plaintiffs would act upon them, which

Plaintiffs did in good faith and to its detriment.

647. Accordingly, Defendants are equitably estopped from relying on any statutes of limitations in defense of this action.

VI. CLAIMS FOR RELIEF

Count I

Violations of the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1962(c)
(against all Defendants)

648. Plaintiffs re-allege and incorporate herein by reference each of the allegations contained in the preceding paragraphs.

649. Plaintiffs bring this count against all Defendants for violations of 18 U.S.C. § 1962(c).

650. Defendants are (1) culpable "persons" who (2) willfully and knowingly (3) committed and conspired to commit two or more acts of mail and wire fraud (4) through a "pattern" of racketeering activity that (5) involves an "association in fact" enterprise, (6) the results of which had an effect on interstate commerce.

A. Defendants Are Culpable "Persons" Under RICO

651. Defendants are "persons" as that term is defined in 18 U.S.C. § 1961(3) because each is capable of holding a legal or beneficial interest in property.

652. Each one of Defendants is a separate entity and "person" that is distinct from the RICO enterprises alleged below.

B. The Manufacturer-PBM RICO Enterprises

653. For the purposes of this claim, the RICO enterprises are nine separate associations-in-fact consisting of one of each of the PBM Defendants and one of each of the Manufacturer Defendants, including those entities' directors, employees, and agents. They are the Eli Lilly-CVS Caremark Enterprise; the Eli Lilly-Express Scripts Enterprise; the Eli Lilly-OptumRx Enterprise; the Novo Nordisk-CVS Caremark Enterprise; the Novo Nordisk-Express Scripts Enterprise; the Novo Nordisk-OptumRx Enterprise; the Sanofi-CVS Caremark Enterprise; the Sanofi-Express Scripts Enterprise; and the Sanofi-OptumRx Enterprise. These association-in-fact enterprises are collectively referred to herein as the "Manufacturer-PBM Enterprises."

654. Each Manufacturer-PBM Enterprise is a separate, ongoing, and continuing business organization consisting of corporations and individuals associated for the common purpose of manufacturing, selling, and facilitating the purchase of the Manufacturer Defendants' products, including the at-issue drugs. For example:

> (a) Each of the three Eli Lilly enterprises associates for the common purpose of manufacturing, selling, distributing, and facilitating the purchase of Eli Lilly medications including Prozac, Cymbalta, and Zyprexa, as well as the at-issue Eli Lilly insulin and insulin-analog medications (Trulicity, Humulin N, Humulin R, Humalog, and Basaglar), which are Eli Lilly's primary source of revenue.
>
> (b) Each of the three Novo Nordisk Enterprises associates for the common

purpose of manufacturing, selling, distributing, and facilitating the purchase of Novo Nordisk medications for the treatment of obesity, hemophilia, and hormone imbalance, as well as the at-issue Novo Nordisk insulin and insulin-analog medications (Novolin R, Novolin N, Novolog, Levemir, Tresiba, Victoza, and Ozempic), which account for more than three-quarters of Novo Nordisk's revenue.

(c) Each of the three Sanofi Enterprises associates for the common purpose of manufacturing, selling, distributing, and facilitating the purchase of Sanofi medications including Ambien, Plavix, and Dupixent, as well as the at-issue Sanofi insulin and insulin-analog medications (Lantus, Toujeo, Apidra, and Soliqua).Each Manufacturer-PBM Enterprise engaged in the shared purpose of exchanging false list prices and secret Manufacturer Payments for preferred formulary positions for the at-issue drugs in order to control the market for diabetes medications and profit off diabetics and payors, including the Plaintiffs.

655. Each Manufacturer-PBM Enterprise engaged in the share purpose of exchanging artificially inflated list prices and secret Manufacturer Payments for preferred formulary positions for the at-issue drugs in order to control the market for diabetes medications and profit off diabetics and payors, including Plaintiffs.

656. The members of each enterprise are bound by contractual relationships, financial ties, and the ongoing coordination of activities.

657. There is also a common communication network by which Defendants share information and meet on a regular basis. These communications include, but are not limited to, communications relating to the use of false list prices for the at-issue diabetes medications and the regular flow of Manufacturer Payments from each Manufacturer Defendant to PBM Defendants in exchange for formulary placement.

658. Each Manufacturer-PBM Enterprise functions as a continuing but separate unit separate and apart from the pattern of racketeering activity in which it engages. Each Manufacturer-PBM Enterprise, for example, engages in the manufacture, distribution, and sale of medications and other products other than the at-issue insulin and insulin-analog medications. Additionally, each Manufacturer engages in conduct other than mail and wire fraud in furtherance of the Insulin Pricing Scheme.

659. At all relevant times, each of the Manufacturer-PBM Enterprises was operated and conducted for unlawful purposes between the Manufacturer Defendants and PBM Defendants, namely, carrying out the Insulin Pricing Scheme.

660. Each Manufacturer-PBM Enterprise derived secret profits from these activities that were greater than those any one of the Manufacturer Defendants or PBMs could obtain absent their misrepresentations regarding their non-transparent pricing schemes.

661. To accomplish this common purpose, each Manufacturer Defendant periodically and systematically inflated the prices of the at-issue drugs and then secretly paid a significant, yet undisclosed, portion of this inflated price back to PBM Defendants in the form of Manufacturer Payments.

662. Each Manufacturer-PBM Enterprise did so willfully and with knowledge that Plaintiffs paid for the at-issue drugs at prices directly based on the

artificially inflated list prices.

663. Each Manufacturer-PBM Enterprise's inflation of the list prices and secret Manufacturer Payments was a quid pro quo exchange for preferred formulary placement.

664. Each Manufacturer-PBM Enterprise concealed from Plaintiffs that these artificially inflated prices and secret Manufacturer Payments resulted in each Manufacturer gaining formulary access without requiring significant price reductions and resulted in higher profits for the PBM Defendants, whose earnings increase the more inflated the price is and the more payments they receive from each Manufacturer Defendant.

665. Each Manufacturer-PBM Enterprise also shares a common purpose of perpetuating the use of the false list prices for the at-issue drugs as the basis for the price that payors, including Plaintiffs, and diabetics pay for diabetes medications.

666. The Manufacturer Defendants would not be able to offer large pricing spreads to PBM Defendants in exchange for favorable formulary positions without the use of the false list prices as the basis for the price paid by diabetics and payors, including Plaintiffs, for the at-issue drugs.

667. The PBM Defendants share this common purpose because nearly all profits and revenues generated from the at-issue drugs are tied to the false inflated prices generated by the Insulin Pricing Scheme. Without diabetics and payors,

including Plaintiffs, paying for diabetes medications based on the inflated list prices, their profits from the Insulin Pricing Scheme would decrease.

668. As a result, PBM Defendants have, with the knowing and willful participation and assistance of each Manufacturer Defendant, engaged in hidden profit-making schemes falling into four general categories: (1) garnering undisclosed Manufacturer Payments from each Manufacturer Defendant that each PBM retains to a large extent; (2) generating substantial profits from pharmacies because of the falsely inflated prices; (3) generating profits on the diabetes medications sold through the PBM Defendants' own mail-order and retail pharmacies; and (4) keeping secret discounts each Manufacturer Defendant provides in association with the PBMs' mail-order and retail operations.

669. At all relevant times, PBM Defendants and each Manufacturer Defendant have been aware of their respective Manufacturer-PBM Enterprise's conduct, have been a knowing and willing participant in and coordinator of that conduct, and have reaped profits from that conduct.

670. None of the PBMs, nor any of the Manufacturer Defendants alone, could have accomplished the purposes of the Manufacturer-PBM Enterprises without the other members of their respective enterprises.

C. The Enterprises Misrepresent and Fail to Disclose Material Facts in Furtherance of the Insulin Pricing Scheme

671. Each Manufacturer-PBM Enterprise knowingly made material

misrepresentations to the public and Plaintiffs in furtherance of the Insulin Pricing Scheme, including publishing artificially inflated prices for insulin on published indices and representing that:

a. the artificially inflated list prices for the at-issue diabetes medications were reasonably related to the actual prices realized by Defendants and were a reasonable and fair basis on which to base the price Plaintiffs paid for these drugs;

b. each Manufacturer priced its at-issue drugs according to each drug's value to the healthcare system and the need to fund innovation;

c. the Manufacturer Payments paid back to the PBMs for each at-issue drug were for Plaintiffs' benefit;

d. all "rebates" and discounts negotiated by the PBMs with the Manufacturer Defendants were passed through to the Plaintiffs;

e. the "rebates" negotiated by the members of each enterprise saved Plaintiffs money;

f. each Manufacturer Defendant and PBM was transparent with Plaintiffs regarding the Manufacturer Payments and the PBMs did not retain any funds associated with prescription drug rebates or any the margin between guaranteed reimbursement rates and the actual amount paid to the pharmacies; and

g. The PBM Defendants constructed formularies in a manner that lowered the price of the at-issue drugs and promoted the health and safety of diabetics.

672. Each artificially inflated list price published by the Manufacturer Defendants constituted a material misrepresentation to Plaintiffs and the public, in that each purported to be a fair market price for the medication at issue, and each omitted the fraudulent spread between the list price and the net price of the medication or the basis therefor. Examples of other specific affirmative representations by each RICO Defendant in furtherance of each enterprise's Insulin

Pricing Scheme are set forth in this Complaint.

673. At all times relevant to this Complaint, each Manufacturer-PBM Enterprise knew the above-described representations to be false.

674. At all times relevant to this Complaint, each Manufacturer-PBM Enterprise intentionally made these representations for the purpose of inducing Plaintiffs into paying artificially inflated prices for diabetes medications.

675. Plaintiffs relied on the material misrepresentations and omissions made by each Manufacturer-PBM Enterprise in paying prices for the at-issue diabetes medications based upon the false prices generated by Insulin Pricing Scheme.

676. Additionally, each PBM-Manufacturer Enterprise relied on the list prices negotiated and published by the other PBM-Manufacturer enterprises in setting their own list prices and determining the value of the kickbacks paid to the PBMs. Plaintiffs were injured by the inflated prices that arose as a result.

677. PBM Defendants convinced Plaintiffs to pay prices for the at-issue drugs based upon the artificially inflated list prices by using the misrepresentations listed above to convince Plaintiffs that they had secured lower prices when, in fact, they did the opposite, all while concealing the Insulin Pricing Scheme.

678. Without these misrepresentations and each RICO Defendant's failure to disclose the Insulin Pricing Scheme, each Manufacturer-PBM Enterprise could not have achieved its common purpose, as Plaintiffs would not have been willing to pay

these artificially inflated list prices.

D. Defendants' Use of the U.S. Mails and Interstate Wire Facilities

679. Each of the Manufacturer-PBM Enterprises engaged in and affected interstate commerce because each engaged in the following activities across state boundaries: the sale, purchase and/or administration of diabetes medications; the setting and publishing of the prices of these drugs; and/or the transmission of pricing information of diabetes medications; and/or the transmission and/or receipt of sales and marketing literature; and/or the transmission of diabetes medications through mail-order and retail pharmacies; and/or the transmission and/or receipt of invoices, statements, and payments related to the use or administration of diabetes medications; and/or the negotiations and transmissions of contracts related to the pricing of and payment for diabetes medications.

680. Each Manufacturer-PBM Enterprise participated in the administration of diabetes medications to millions of individuals located throughout the United States, including in Pennsylvania.

681. Each Manufacturer Defendant's and PBM Defendant's illegal conduct and wrongful practices were carried out by an array of employees, working across state boundaries, who necessarily relied upon frequent transfers of documents and information and products and funds through the U.S. mails and interstate wire facilities.

682. The nature and pervasiveness of the Insulin Pricing Scheme, which included Manufacturer Defendants' and PBM Defendants' corporate headquarters operations, necessarily required those headquarters to communicate directly and frequently by the U.S. mails and by interstate wire facilities with each other and with pharmacies, physicians, payors, and diabetics throughout Pennsylvania.

683. Each Manufacturer-PBM Enterprise's use of the U.S. mails and interstate wire facilities to perpetrate the Insulin Pricing Scheme involved thousands of communications including:

a. marketing materials about the published prices for diabetes medications, which each Manufacturer Defendant sent to the PBM Defendants located across the country, including throughout Pennsylvania;

b. written and oral representations of the false list prices of diabetes medications that Manufacturer Defendants and PBM Defendants made at least annually and, in many cases, several times during a single year to the public;

c. thousands of written and oral communications discussing, negotiating, and confirming the placement of each Manufacturer Defendant's diabetes medications on the PBM Defendants' formularies;

d. written and oral representations made by each Manufacturer Defendant regarding information or incentives paid back to PBM Defendants for each diabetes medications sold and/or to conceal these incentives or the Insulin Pricing Scheme;

e. written communications made by each Manufacturer Defendant, including checks, relating to Manufacturer Payments paid to the PBM Defendants to persuade them to advocate the at-issue diabetes medications;

f. written and oral communications with U.S. government agencies that misrepresented what the published prices were or that were intended to deter investigations into the true nature of the published prices or to forestall changes to reimbursement based on something other than published prices;

g. written and oral communications with payors, including Plaintiffs, regarding the prices of diabetes medications;

h. written and oral communications to Plaintiffs, including marketing and solicitation material sent by the PBM Defendants regarding the existence, amount, or purpose of payments made by each Manufacturer Defendant to PBM Defendants for the diabetes medications described herein and the purpose of the PBM Defendants' formularies;

i. transmission of published prices to third parties and payors, including Plaintiffs; and

j. receipts of money on at least tens of thousands of occasions through the U.S. mails and interstate wire facilities—the wrongful proceeds of the Insulin Pricing Scheme.

684. Although Plaintiffs pleads the dates of certain communications in allegations incorporated into this Count, it cannot allege the precise dates of others without access to books and records within each RICO Defendant's exclusive custody and control. Indeed, an essential part of the successful operation of the Insulin Pricing Scheme depended upon secrecy, and Manufacturer Defendants and PBM Defendants took deliberate steps to conceal its wrongdoing.

E. Conduct of the Manufacturer-PBM Enterprises' Affairs

685. PBM Defendants and each Manufacturer Defendant participates in the operation and management of Manufacturer-PBM Enterprises with which it is associated and, in violation of Section 1962(c) of RICO, and conducts or participates in the conduct of the affairs of those association-in-fact RICO enterprises, directly or indirectly. Such participation is carried out in the following ways, among others:

a. Each Manufacturer Defendant directly controls the secret Manufacturer

Payments it provides to the PBMs for its diabetes medications.

b. PBM Defendants directly manage and control their drug formularies and the placement of the at-issue diabetes medications on those formularies.

c. PBM Defendants intentionally select higher-priced diabetes medications for formulary placement and exclude lower priced ones in order to generate larger profits and coordinate with the Manufacturer Defendants to increase the availability and use of higher-priced medications because they are more profitable for both groups of Defendants.

d. Each Manufacturer Defendant directly controls the publication of the false list prices generated by the Insulin Pricing Scheme.

e. Each Manufacturer Defendant directly controls the creation and distribution of marketing, sales and other materials used to inform the PBMs of the profit potential from its diabetes medications.

f. PBM Defendants directly control the creation and distribution of marketing, sales, and other materials used to inform payors and the public of the benefits and cost-saving potential of PBM Defendants' formularies and negotiations with the Manufacturers.

g. PBM Defendants direct and control each enterprise's direct relationships with payors such as Plaintiffs by negotiating the terms of and executing the contracts that govern those relationships.

h. PBM Defendants direct and control each enterprise's Insulin Pricing Scheme by hiding, obfuscating, and laundering Manufacturer Payments through their affiliated entities in order to retain a large and undisclosed proportion of the Manufacturer Payments to the detriment of payors, including Plaintiffs.

i. PBM Defendants distribute through the U.S. mail and interstate wire facilities promotional and other materials which claim that the Manufacturer Payments paid from each Manufacturer Defendant to PBM Defendants save Plaintiffs and other payors' money on the at-issue drugs.

j. Each Manufacturer Defendant represented to the Plaintiffs—by publishing and promoting false list prices without stating that these published prices differed substantially from the prices realized by Manufacturer Defendants and PBM Defendants—that the published prices of diabetes medications reflected or approximated the actual price realized by Defendants and resulted from transparent and competitive fair market forces.

F. Defendants' Patterns of Racketeering Activity

686. Manufacturer Defendants and PBM Defendants haves conducted and participated in the affairs of their respective Manufacturer-PBM Enterprises through a pattern of racketeering activity, including acts that are unlawful under 18 U.S.C. § 1341, relating to mail fraud, and 18 U.S.C. § 1343, relating to wire fraud.

687. Manufacturer Defendants' and PBM Defendants' pattern of racketeering involved thousands, if not hundreds of thousands, of separate instances of use of the U.S. mails or interstate wire facilities in furtherance of the Insulin Pricing Scheme. Each of these mailings and interstate wire transmissions constitutes a "racketeering activity" within the meaning of 18 U.S.C. § 1961(1). Collectively, these violations constitute a "pattern of racketeering activity," within the meaning of 18 U.S.C. § 1961(5), in which Manufacturer Defendants and PBM Defendants intended to defraud Plaintiffs.

688. By intentionally and falsely inflating the list prices, by misrepresenting the purpose behind both the Manufacturer Payments (made from each Manufacturer Defendant to the PBM Defendants) and PBM Defendants' formulary construction, and by subsequently failing to disclose such practices to Plaintiffs, Manufacturer Defendants and PBM Defendants engaged in a fraudulent and unlawful course of conduct constituting a pattern of racketeering activity.

689. Manufacturer Defendants' and PBM Defendants' racketeering activities

amounted to a common course of conduct, with similar patterns and purposes, intended to deceive Plaintiffs.

690. Each separate use of the U.S. mails and/or interstate wire facilities employed by Manufacturer Defendants and PBM Defendants was related, had similar intended purposes, involved similar participants and methods of execution, and had the same results affecting the same victims, including Plaintiffs.

691. Manufacturer Defendants and PBM Defendants engaged in the pattern of racketeering activity for the purpose of conducting the ongoing business affairs of the respective Manufacturer-PBM Enterprises with which each of them is and was associated in fact.

G. The RICO Defendants' Motives

692. Manufacturer Defendants' and PBM Defendants' motives in creating and operating the Insulin Pricing Scheme and conducting the affairs of the Manufacturer-PBM Enterprises described herein was to control the market for diabetes medications, exclude competition, and maximize sales of, and profits from, diabetes medications.

693. The Insulin Pricing Scheme was designed to, and did, encourage others, including payors like Plaintiffs, directly and/or through its agents, to advocate the use of each Manufacturer Defendant's respective products and to pay for those diabetes medications based on a falsely inflated price. Each Manufacturer Defendant

used the Insulin Pricing Scheme to obtain formulary placement to sell more of its drugs without having to cut into its profits. The PBM Defendants used the Insulin Pricing Scheme to falsely inflate the price payors such as the Plaintiffs, through its agents, paid for diabetes medications in order to profit off the Insulin Pricing Scheme, as discussed above.

H. The Manufacturer-PBM Enterprises' Insulin Pricing Scheme Injured Plaintiffs.

694. Each Manufacturer-PBM Enterprise's violations of federal law and pattern of racketeering activity have directly and proximately caused the Plaintiffs to be injured in its business or property.

695. The prices the Plaintiffs, directly and/or through their agents, pay for the at-issue drugs are directly tied to the false list prices generated by the Insulin Pricing Scheme.

696. No other intermediary in the supply chain has control over or is responsible for the list prices on which nearly all Plaintiffs' payments are based other than the Manufacturer-PBM Defendant Enterprises.

697. Defendants collectively set the prices that the Plaintiffs, through its agents, paid for the at-issue diabetes medications.

698. During the relevant period, CVS Caremark and various nonparties set forth in paragraph 48 herein provided PBM services to the Plaintiffs, directly and/or through its agents, and benefited therefrom.

699. During the relevant period, the Plaintiffs, directly and/or through its agents, paid CVS Caremark and the various PBM entities as set forth in paragraph 48 herein for the at-issue drugs.

700. Each Manufacturer-PBM Enterprise, controlled and participated in the Insulin Pricing Scheme, which was directly responsible for the false list prices upon which the price Plaintiffs paid, directly and through their agents, was based.

701. Thus, Plaintiffs were damaged by reason of the Insulin Pricing Scheme. But for the misrepresentations and false prices created by the Insulin Pricing Scheme that each Manufacturer–PBM Enterprise employed, Plaintiffs, through its agents, would have paid less for diabetes medications.

702. Because the Insulin Pricing Scheme resulted in payors and consumers paying supercompetitive prices for the at-issue medications, the scheme could not have continued without each Manufacturer-PBM Enterprise's participation. In other words, if one of the Manufacturer-PBM Enterprises had opted not to participate in the scheme—and not inflated its list prices—the other enterprises could not have continued to overcharge their own clients. Each enterprise's participation in the scheme—and execution of its own pattern of racketeering activity—was essential to the overall scheme's survival and a direct cause of Plaintiffs' injuries.

703. While Defendants' scheme injured an enormous number of payors and plan members, Plaintiffs' damages are separate and distinct from those of any other

victim that was harmed by the Manufacturer–PBM Defendant Enterprises' Insulin Pricing Scheme.

704. By virtue of these violations of 18 U.S.C. § 1962(c), under the provisions of Section 1964(c) of RICO, Defendants are jointly and severally liable to the Plaintiffs for three times the damages that were sustained, plus the costs of bringing this suit, including reasonable attorneys' fees.

705. By virtue of these violations of 18 U.S.C. § 1962(c), under the provisions of Section 1964(a) of RICO, the Plaintiffs seeks injunctive relief against Manufacturer Defendants and PBM Defendants for their fraudulent reporting of their prices and their continuing acts to affirmatively misrepresent and/or conceal and suppress material facts concerning their false and inflated prices for diabetes medications, plus the costs of bringing this suit, including reasonable attorneys' fees.

706. Absent an injunction, the effects of this fraudulent, unfair, and unconscionable conduct will continue. Plaintiffs, directly and/or through its agents, continues to purchase the at-issue diabetes medications. Plaintiffs, directly and through their agents, will continue to pay based on the Defendants' false list prices. This continuing fraudulent, unfair, and unconscionable conduct is a serious matter that calls for injunctive relief as a remedy. Plaintiffs seek injunctive relief, including an injunction against Manufacturer Defendants and PBM Defendants, to prevent them from affirmatively misrepresenting and/or concealing and suppressing material

facts concerning their conduct in furtherance of the Insulin Pricing Scheme.

Count II

Violations of RICO, 18 U.S.C. § 1962(d) by Conspiring to Violate 18 U.S.C. § 1962(c)

(against all Defendants)

707. Plaintiffs re-allege and incorporate herein by reference the allegations set forth in the preceding paragraphs.

708. Section 1962(d) of RICO provides that it "shall be unlawful for any person to conspire to violate any of the provisions of subsection (a), (b) or (c) of this section."

709. Defendants have violated § 1962(d) by agreeing and conspiring to violate 18 U.S.C. § 1962(c). The object of this conspiracy has been and is to conduct or participate in the Insulin Pricing Scheme.

710. As set forth in detail above, Defendants each knowingly agreed to facilitate the Insulin Pricing Scheme, and each has engaged in numerous overt and predicate fraudulent racketeering acts in furtherance of the conspiracy. Specifically, Defendants agreed to and did inflate the prices of the at-issue drugs in lockstep to achieve an unlawful purpose; Defendants agreed to and did make false or misleading statements or material omissions regarding the reasons for these price increases, the purpose of the Manufacturer Payments exchanged between Defendants, and the PBMs' formulary construction; and the PBMs agreed to and did, in concert, request

and receive larger Manufacturer Payments and higher prices in exchange for formulary placement.

711. The nature of the above-described Defendant co-conspirators' acts, material misrepresentations, and omissions in furtherance of the conspiracy gives rise to an inference that they not only agreed to the objective of an 18 U.S.C. § 1962(d) violation of RICO by conspiring to violate 18 U.S.C. § 1962(c), but they were aware that their ongoing fraudulent and extortionate acts have been and are part of an overall pattern of racketeering activity.

712. Defendants have engaged and continue to engage in the commission of overt acts, including the following unlawful racketeering predicate acts:

a. multiple instances of mail fraud in violations of 18 U.S.C. § 1341;

b. multiple instances of wire fraud in violations of 18 U.S.C. § 1343; and

c. multiple instances of unlawful activity in violation of 18 U.S.C. § 1952.

713. Defendants' conspiracy to violate the above federal laws and the effects thereof detailed above are continuing and will continue. Plaintiffs have been injured in its property by reason of these violations: Plaintiffs, directly and/or through their agents, have paid more for the at-issue drugs than it would have but for Defendants' conspiracy to violate 18 U.S.C. § 1962(c).

714. By virtue of these violations of 18 U.S.C. § 1962(d), Defendants are jointly and severally liable to Plaintiffs for three times the damages this District has sustained, plus the cost of this suit, including reasonable attorneys' fees.

Count III

Violation of Pennsylvania Unfair Trade Practices and Consumer Protection Law, 73 P.S. §§ 201-1 – 201-9.3

(against Defendants Eli Lilly, Novo Nordisk, Sanofi, and CVS Caremark)

715. Plaintiffs re-allege all prior paragraphs of this Complaint as if set forth fully herein.

716. Plaintiffs bring this claim against Defendants Eli Lilly, Novo Nordisk, Sanofi, and CVS Caremark. All are referred to collectively throughout the Count as "UTPCPL Defendants." Eli Lilly, Novo Nordisk and Sanofi are referred to throughout the Count as "Manufacturer Defendants." CVS Caremark is referred to throughout the Count as "UTPCPL PBM Defendant."

717. This Count does not sound in fraud.

718. The Pennsylvania Unfair Trade Practices and Consumer Protection Law ("UTPCPL") prohibits companies from employing "[u]nfair methods of competition" and "unfair or deceptive acts or practices," which are defined to include, *inter alia*, the following conduct:

- "Representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits or quantities that they do not have . . . ." 73 P.S. § 201-2 (4)(v); or
- Making false or misleading statements of fact concerning the reasons for, existence of, or amounts of price reductions. 73 P.S. § 201-2(4)(xi); or

- "Engaging in any other fraudulent or deceptive conduct which creates a likelihood of confusion or of misunderstanding." 73 P.S. § 201-2 (4)(xxi).

719. Each UTPCPL Defendant is a "person" within the meaning of the UTPCPL, 73 P.S. § 201-2(11).

720. Plaintiffs operate as a consumer when it purchases, through its agents, goods, or services, which it does when it pays for the procurement of and/or reimbursement for diabetes medications, directly and/or through its agents.

721. UTPCPL Defendants are independently liable for their own misconduct in violation of the UTPCPL and are liable for their collective efforts in furtherance of the Insulin Pricing Scheme. Using a complex structure of interdependent entities, UTPCPL Defendants confused and misled consumers about each UTPCPL Defendant's respective role in an attempt to evade liability for the unfair and deceptive scheme as a whole, and for the acts and omissions of the enterprises' interdependent participants.

722. UTPCPL Defendants' misconduct in violation of the UTPCPL includes the creation and implementation of the Insulin Pricing Scheme, which included:

- The Manufacturer Defendants published prices for the at-issue drugs and, in doing so, held these prices out as the actual prices for these drugs despite knowing these prices were artificially inflated and untethered from either the actual cost of the drugs or the price the Manufacturers were paid for them—all with CVS Caremark's knowledge, consent, and cooperation.

- The Manufacturer Defendants misrepresented and actively concealed the true reasons why they set and raised list prices—the truth being that it was to increase revenues and profits and to offer higher prices and larger Manufacturer Payments to CVS Caremark —all with CVS Caremark's knowledge, consent, and cooperation.

- CVS Caremark furthered the scheme by using the artificially inflated list prices to determine the inflated prices paid by payors, including Plaintiffs, through its agents—all with the Manufacturer Defendants' knowledge, consent, and cooperation.

- CVS Caremark represented to payors, including Plaintiffs, through its agents, and the public that it worked to generate savings with respect to the at-issue drugs and to promote the health of diabetics. Instead, directly counter to its representations, CVS Caremark drove up the prices of the at-issue drugs and damaged payors, including Plaintiffs, through its agents, and patients by demanding ever-increasing Manufacturer Payments that, in turn, increased what otherwise would have been the retail prices for the at-issue drugs—all with the Manufacturer Defendants' knowledge, consent, and cooperation.

- CVS Caremark has hidden, obfuscated, and laundered these Manufacturer Payments through its affiliated entities in order to retain a large and undisclosed proportion of the Manufacturer Payments to the detriment of payors, including Plaintiffs, through its agents, and patients.

- CVS Caremark intentionally selected higher-priced diabetes medications for formulary placement and excluded lower priced ones in order to generate larger profits and coordinated with the Manufacturer Defendants to increase the availability and use of higher priced medications because they are more profitable for both groups of Defendants.

- CVS Caremark misled payors and / or their agents as to the true nature of value of the services it provided and reaped illicit profits exponentially greater than the fair market value of the services it purported to provide—all with the Manufacturer Defendants' knowledge, consent, and cooperation.

- CVS Caremark owed a duty to disclose the true facts to its payor clients, including Plaintiffs, through its agents, but intentionally chose instead to conceal them, both to further the Insulin Pricing Scheme and to conceal it from payors, including Plaintiffs through its agents—all with the Manufacturer Defendants' knowledge, consent, and cooperation.

723. By jointly carrying out and concealing the Insulin Pricing Scheme, as described herein, UTPCPL Defendants misrepresented the characteristics and benefits of their goods and services, 73 P.S. § 201-2(4)(v), made false or misleading statements of fact concerning the reasons for, existence of, or amounts of price reductions, 73 P.S. § 201-2(4)(xi), and engaged in fraudulent or deceptive conduct which creates a likelihood of confusion or of misunderstanding, 73 P.S. § 201-2(4)(xxi), including by, but not limited to, the following conduct:

a. A characteristic of every commodity is its price, which is represented by every seller to every buyer that the product being sold is being sold at a legal, competitive, and fair market value.

b. The Manufacturer Defendants reported and published artificially inflated list prices for each at-issue drug and, in doing so, represented that the reported prices were reasonably related to the net prices for the at-issue drugs and otherwise reflected the fair market value for the drugs—all with CVS Caremark's knowledge, consent, and cooperation.

c. CVS Caremark misrepresented to payors, including Plaintiffs, through its agents, and the public that its formularies and the portion of the Manufacturer Payments it disclosed has the characteristic and benefit of lowering the price of the at-issue drugs and promoting the health of diabetics when, in fact, the opposite is true.

d. CVS Caremark utilized the artificially inflated price—which it is directly responsible for inflating and which it knows is untethered from the actual price—to make false and misleading statements regarding the amount of savings the PBMs generate for payors, including Plaintiffs, through its agents, patients, and the public.

e. UTPCPL Defendants made false and misleading representations of fact that the prices for the at-issue diabetes medications were legal, competitive, and fair market value prices.

f. At no point did UTPCPL Defendants reveal that the prices for the at-issue drugs were not legal, competitive or at fair market value—rather, they coordinated to overtly mislead the public and payors, including Plaintiffs, through its agents, and undertook a concerted effort to conceal the truth.

g. At no point did UTPCPL Defendants disclose that the prices associated with the at-issue drugs were generated by the Insulin Pricing Scheme—rather, they overtly misled the public and payors, including Plaintiffs, through its agents, and undertook a concerted effort to conceal the truth.

h. At least once a year for each year during the relevant period, UTPCPL Defendants reported and published false prices for each at-issue drug and in doing so represented that the list prices were the actual, legal, and fair prices for these drugs and resulted from competitive market forces when they knew that was not true.

i. In addition, by granting the at-issue drugs preferred formulary position—formulary positions that the PBMs represent are reserved for reasonably priced drugs and that are meant to promote cost savings and the health of diabetics— CVS Caremark knowingly and purposefully utilized the false prices that were generated by the Insulin Pricing Scheme—all with the Manufacturer Defendants knowledge, consent, and cooperation.

j. By granting the at-issue diabetes medications preferred formulary positions, CVS Caremark ensured that prices generated by the Insulin Pricing Scheme would harm payors, including Plaintiffs, through its agents, and patients—all with the Manufacturer Defendants knowledge, consent, and cooperation.

k. CVS Caremark also misrepresented its formularies promoted cost-savings to payors, including Plaintiffs, through its agents, and patients.

l. UTPCPL Defendants' representations are false, and they knew they were false when they were made. Defendants knew that the prices they reported and utilized were artificially inflated for the purpose of maximizing revenues and profits pursuant to the Insulin Pricing Scheme.

m. UTPCPL Defendants not only knew that the PBMs' formulary construction fueled the precipitous price increases that damaged the financial well-being of payors, including Plaintiffs, and often the health of diabetics, but coordinated in ways that made such harm inevitable—all for the sole purpose of generating more revenues and profits for both groups of Defendants.

n. Defendants affirmatively withheld this truth from payors, including Plaintiffs, through its agents, even though these Defendants knew that payors, including Plaintiffs, through its agents, sought to pay the lowest possible price for diabetes medications and that their expectation was to pay a legal, competitive price that resulted from transparent market forces.

o. UTPCPL Defendants made false and misleading misrepresentations of fact related to the Manufacturer Payments and the negotiations that occurred between CVS Caremark and Manufacturer Defendants.

p. CVS Caremark knowingly made false and misleading statements concerning the reasons for, existence of, and amount of price reductions by misrepresenting that the Manufacturer Payments lower the overall price of diabetes medications and reduce payor costs while promoting the health of diabetics.

q. These representations were false, and UTPCPL Defendants knew they were false when they were made. CVS Caremark knew that the Manufacturer Payments were not reducing the overall price of diabetes medications but rather are an integral part of the secret Insulin Pricing Scheme and are responsible for the inflated prices.

r. CVS Caremark owed a duty to disclose the true facts to its payor clients, including Plaintiffs, through its agents, but intentionally chose instead to conceal them, both to further the Insulin Pricing Scheme and to conceal it from payors, including Plaintiffs, through its agents—all with the intent of misrepresenting the characteristics and benefits of its services and the existence and nature of purported price reductions they obtained for payors, including Plaintiffs, through its agents. All of this was done with the Manufacturer Defendants' knowledge, consent, and cooperation.

s. Defendants continue to make these misrepresentations and to publish prices generated by the Insulin Pricing scheme, and payors, including Plaintiffs, through its agents, and patients continue to purchase diabetes medications at inflated prices.

t. Defendants' conduct, including but not limited to their concealment of information regarding pricing and fee arrangements, which contributed to inflated, fictitious prices, created a likelihood that payors, including Plaintiffs, through its agents, and patients did not understand that the prices they were paying for insulin were artificially inflated prices rather than competitive market prices.

724. UTPCPL Defendants' conduct as described herein is also "unfair" within the meaning of the UTPCPL because it is unconscionable, offends public policy, and is unethical, oppressive, and unscrupulous. UTPCPL Defendants took advantage of their concentrated market power to artificially inflate prices for insulin, a life-saving drug for diabetics, for the purpose of increasing their profits. The Insulin Pricing Scheme put UTPCPL Defendants' profits over patient safety in that prices for insulin were set so high that patients' access to those life-saving drugs was jeopardized.

725. UTPCPL Defendants knew that the representations and omissions described above were false when made—the rebates and formulary positions agreed upon between UTPCPL Defendants did not lower the price paid for insulin by payors, including Plaintiffs, but rather were primary factors driving the exponential increase in the amount paid for insulins in Pennsylvania during the relevant timeframe.

726. UTPCPL Defendants made these false representations to payors, including Plaintiffs, through its agents, and the public through, among other things, oral and written communications, the inclusion of the reported price in their contracts with payors and / or their agents as a determinant of the price for diabetes medications, marketing materials, presentations, publications of the artificially inflated reported price, and in public statements.

727. UTPCPL Defendants misrepresented facts about the cause of skyrocketing insulin prices. These misrepresentations were directed at and affected payors, including Plaintiffs, through its agents, and the public in Pennsylvania.

728. As a direct result of the unfair or deceptive acts or practices described herein, UTPCPL Defendants have received, and will continue to receive, income, profits, and other benefits, which they would not have received if they had not engaged in violations of the UTPCPL.

729. As a direct result of the unfair or deceptive acts or practices described herein, UTPCPL Defendants have caused Plaintiffs and other persons in interest to incur, and continue to incur, enormous costs and expenses, including but not limited to paying excessive and inflated prices for the at-issue diabetes medications.

730. But for UTPCPL Defendants' deceptive conduct in violation of the UTPCPL, Plaintiffs would not have expended millions of dollars in connection with the purchase or reimbursement of diabetes medications. As a direct and proximate result of Defendants' deceptive conduct, Plaintiffs have been injured.

731. Plaintiffs have suffered economic injuries that are direct, ascertainable, and quantifiable. Plaintiffs' damages constitute both an "ascertainable loss of money or property" and "actual damages" for purposes of 73 P.S. § 201-9.2(a).

Count IV

Violations of New Jersey Consumer Fraud Act (N.J.S.A. § 56:8-1, et seq.)

(against Defendants Eli Lilly, Novo Nordisk, Sanofi, and CVS Caremark)

732. Plaintiffs incorporate by reference all preceding paragraphs and re-alleges them as if set forth fully herein.

733. Plaintiffs bring this claim against CVS Caremark (as defined collectively herein) and the Manufacturer Defendants. All are referred to collectively throughout Count IV as "Count IV Defendants."

734. At all relevant times material hereto, Defendants conducted trade and commerce within the meaning of the New Jersey Consumer Fraud Act, N.J.S.A. § 56:8-1, et seq. ("New Jersey CFA").

735. Plaintiffs and each of the Defendants are "persons" within themeaning of, and subject to, N.J.S.A. 56:8-1(d).

736. The at-issue diabetes drugs are "merchandise," which is defined to include any objects, goods, and commodities offered, directly or indirectly, to the public for sale. N.J.S.A. § 56:8-1(c).

737. Defendants each engaged in "sales" of "merchandise" within the meaning of N.J.S.A. § 56:8-1(c) and (d), which includes "any sale, rental or distribution, offer for sale, rental or distribution or attempt directly or indirectly to sell, rent or distribute," N.J.S.A. § 56:8-1(e), and therefore includes Defendants' sale of the at-issue diabetes drugs to Plaintiffs.

738. The New Jersey CFA protects consumers like Plaintiffs against fraud, unlawful practices, and unconscionable commercial practices in connection with the sale of any merchandise.

739. The New Jersey CFA makes unlawful "[t]he act, use or employment by any person of any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing, concealment, suppression, or omission of any material fact with intent that others rely upon such concealment, suppression or omission, in connection with the sale or advertisement of any merchandise or real estate . . . whether or not any person has in fact been misled, deceived or damaged thereby, is declared to be an unlawful practice . . . . " N.J.S.A. § 56:8-2.

740. Defendants engaged in unfair, false, deceptive, and misleading practices that violated N.J.S.A. § 56:8-2, et seq., as described herein, through their creation of, participation in, and effectuating the Insulin Pricing Scheme. In particular, and with respect to the Manufacturer Defendants, CVS Caremark, and Plaintiffs in this case:

a. The Manufacturer Defendants published prices for the at-issue drugs and, in doing so, held these prices out as the actual prices for these drugs despite knowing these prices were artificially inflated and untethered from the cost of the drugs or the price the Manufacturers were paid for them—all with the PBM Defendants' knowledge, consent, and cooperation.

b. The Manufacturer Defendants misrepresented and actively concealed the true reasons why they set and raised list prices—the truth being that it was to increase revenues and profits and to offer higher prices and larger Manufacturer Payments to the PBMs—all with the PBM Defendants' knowledge, consent, and cooperation.

c. The PBM Defendants furthered the scheme by using the artificially inflated list prices to determine the inflated prices paid by payors, including Plaintiffs—all with the Manufacturer Defendants' knowledge, consent, and cooperation.

d. The PBM Defendants represented to payors, including Plaintiffs, and to the public that they worked to generate savings with respect to the at issue drugs and to promote the health of diabetics. CVS Caremark made such representations to Plaintiffs. Instead, directly counter to those representations, the PBM Defendants drove up the prices of the at-issue drugs and damaged payors, including Plaintiffs, by demanding ever-increasing Manufacturer Payments that, in turn, increased what otherwise would have been the retail prices for the at-issue drugs—all with the Manufacturer Defendants' knowledge, consent, and cooperation.

e. The PBM Defendants have hidden, obfuscated, and laundered these Manufacturer Payments through their affiliated entities so as to retain a large and undisclosed proportion of the Manufacturer Payments to the detriment of payors, including Plaintiffs.

f. The PBM Defendants intentionally selected higher-priced diabetes medications for formulary placement and excluded lower priced ones in order to generate larger profits and coordinated with the Manufacturer Defendants to increase the availability and use of higher priced medications because they are more profitable for both the PBM and Manufacturer Defendants. CVS engaged in such conduct here with respect to Plaintiffs' formularies.

g. The PBM Defendants misled their payors, including Plaintiffs, as to the true nature of value of the services they provided and reaped illicit profits greater than the fair market value of the services they purported to provide—all with the Manufacturer Defendants' knowledge, consent, and cooperation.

h. The PBM Defendants owed a duty to disclose the true facts to their payor clients, including Plaintiffs, but intentionally chose instead to conceal them, both to further the Insulin Pricing Scheme and to conceal it from payors, including Plaintiffs—all with the Manufacturer Defendants' knowledge, consent, and cooperation.

741. In addition, Defendants made numerous false and misleading statements of fact concerning the existence of, reasons for, and amounts of purported price reductions.

a. A characteristic of every product in New Jersey is its price, which is represented by every seller to every buyer that the product being sold is being sold at a legal, competitive, and fair market value. The Manufacturer Defendants reported and published artificially inflated list prices for each at issue drug and, in doing so, represented that the reported prices were reasonably related to the net prices for the at-issue drugs and otherwise reflected the fair market value for the drugs—all with the PBM Defendants' knowledge, consent, and cooperation.

b. The PBM Defendants misrepresented to payors like Plaintiffs and to the public that their formularies and the portion of the Manufacturer Payments they disclosed have the characteristic and benefit of lowering the price of the at-issue drugs and promoting the health of diabetics when, in fact, the opposite is true.

c. The PBM Defendants utilized the artificially inflated price—which they are directly responsible for inflating and which they know is

untethered from the actual price—to make false and misleading statements regarding the amount of savings the PBMs generate for payors and the public.

d. Defendants made false and misleading representations of fact that the prices for the at-issue diabetes medications were legal, competitive, and fair market value prices.

e. At no point did the Defendants reveal that the prices for the at issue drugs were not legal, competitive, or at fair market value—rather, they coordinated to overtly mislead the public and payors, including Plaintiffs, and undertook a concerted effort to conceal the truth.

f. At no point did these Defendants disclose that the prices associated with the at-issue drugs were generated by the Insulin Pricing Scheme—rather, they overtly misled the public and payors, including Plaintiffs, and undertook a concerted effort to conceal the truth.

g. At least once per year for each year during the relevant period, Manufacturer Defendants reported and published false prices for each at-issue drug and in doing so represented that the list prices were the actual, legal, and fair prices for these drugs and resulted from competitive market forces when they knew that was not the case.

h. By granting the at-issue drugs preferred formulary position (which PBM Defendants represent are reserved for reasonably priced drugs and which are purportedly designed to promote cost savings and the health of diabetics), the PBM Defendants knowingly and purposefully utilized the false prices that were generated by the Insulin Pricing Scheme—all with the Manufacturer Defendants knowledge, consent, and cooperation.

i. By granting the at-issue diabetes medications preferred formulary positions, the PBM Defendants (here, CVS) ensured that prices generated by the Insulin Pricing Scheme would harm Plaintiffs—all with the Manufacturer Defendants knowledge, consent, and cooperation.

j. The PBM Defendants (here, CVS) also misrepresented their formularies promoted the cost-savings to Plaintiffs.

k. Defendants' representations are false and Defendants knew they were false when they were made. Defendants knew that the prices they reported and utilized are artificially inflated for the purpose of maximizing revenues and profits pursuant to the Insulin Pricing Scheme.

l. Defendants not only knew that the PBMs' formulary construction fueled the precipitous price increases that damaged Plaintiffs' financial wellbeing, but coordinated in ways that made such harm inevitable—all for the sole purpose of generating more revenues and profits for both groups of Defendants.

m. Defendants affirmatively withheld this truth from Plaintiffs, even though these Defendants knew that the Plaintiffs' intention was to pay the lowest possible price for diabetes medications and expectation was to pay a legal, competitive price that resulted from transparent market forces.

n. Defendants made false and misleading misrepresentations of fact related to the Manufacturer Payments and the negotiations that occurred between the PBM and Manufacturer Defendants.

o. PBM Defendants knowingly made false and misleading statements concerning the reasons for, existence of, and amount of price reductions by misrepresenting that the Manufacturer Payments

lower the overall price of diabetes medications and reduce payor costs while promoting the health of diabetics.

p. Defendants knew that these representations were false when they were made. Defendants knew that the Manufacturer Payments were not reducing the overall price of diabetes medications but rather are an integral part of the secret Insulin Pricing Scheme and are responsible for the inflated prices.

q. The PBM Defendants (here, CVS) owed a duty to disclose the true facts to their payor clients, including Plaintiffs, but intentionally chose instead to conceal them, both to further the Insulin Pricing Scheme and to conceal it from payors like Plaintiffs—all with the intent of misrepresenting the characteristics and benefits of their services and the existence and nature of purported price reductions they obtained for those payors. All of this was done with the Manufacturer Defendants' knowledge, consent, and cooperation.

r. Defendants continue to make these misrepresentations and to publish prices generated by the Insulin Pricing scheme, and Plaintiff continues to be constrained to purchase diabetes medications at exorbitant prices.

742. Defendants' unfair or deceptive acts or practices, including its misrepresentations, concealments, omissions, and/or suppressions of material facts, had a tendency or capacity to mislead and create a false impression in payors like Plaintiff, and were likely to and did in fact deceive those payors.

743. In addition, the acts and practices alleged herein are ongoing, repeated, and affect the public interest. The acts and practices alleged herein substantially harm the community of diabetics, their families, healthcare providers, consumers in

general, and the public at large, and have caused substantial actual harm, including to Plaintiffs and their beneficiaries. Because of the Insulin Pricing Scheme, payors (including Plaintiffs) and patients have paid inflated prices for the at-issue drugs. Beyond inflicting monetary harm, Defendants' conduct restricted affordable access to diabetes drugs, forcing diabetics to ration—or forego—necessary treatment. The Insulin Pricing Scheme has thus had a broad impact on consumers at large in New Jersey.

744. In purchasing the at-issue diabetes drugs, Plaintiffs relied on the misrepresentations and/or omissions of Defendants.

745. As a direct and proximate result of Defendants' wrongful conduct in violation of the New Jersey CFA, Plaintiffs have suffered and continue to suffer harm and ascertainable loss as purchasers of the at-issue drugs, and damages to be determined at trial, including but not limited to the Plaintiffs paying excessive and inflated prices for diabetes medications described herein every time they paid for an at-issue drug.

746. Additionally, Plaintiffs did not receive the benefit of their bargain, or otherwise paid a price premium, for the at-issue diabetes medications because they paid an artificially inflated price due to these Defendants' illegal practices.

747. As a result of Defendants' fraudulent and/or deceptive conduct, misrepresentations, and/or knowing omissions, Plaintiffs are entitled to actual

damages, treble damages, costs, attorneys' fees, and other damages to be determined at trial. See N.J.S.A. § 56:8-19.

Count V

Common Law Fraud Under Pennsylvania and New Jersey Law

(against Defendants Eli Lilly, Novo Nordisk, Sanofi, and CVS Caremark)

748. Plaintiffs re-allege and incorporate herein by reference each of the allegations from the preceding paragraphs.

749. Plaintiffs bring this claim against Defendants Eli Lilly, Novo Nordisk, Sanofi, and CVS Caremark. All are referred to collectively throughout this Count as "Common Law Fraud Defendants." Eli Lilly, Novo Nordisk and Sanofi are referred to throughout the Count as "Manufacturer Defendants." CVS Caremark is referred to throughout the Count as "Common Law Fraud PBM Defendant."

750. CVS Caremark and the Manufacturer Defendants affirmatively misrepresented, omitted, or concealed and suppressed material facts concerning, among other things:

a. the true cost and price of the at-issue drugs; s

b. the inflated and fraudulent nature of the list prices set and charged by Defendants for the at-issue drugs;

c. the existence, amount, flow, and purposes of discounts and rebates offered or negotiated by Defendants for the at-issue medications; and

d. the role that Defendants played in the price paid for the at-issue, including marketing materials and other public statements stating that Defendants decrease the price of prescription drugs for consumers.

751. These Defendants' false representations and omissions were material to Plaintiffs.

752. Common Law Fraud Defendants knew that their representations and omissions were false and misleading. They knew, for example, that the list prices for the at-issue drugs were excessive, inflated, and untethered to any competitive market price. They knew that these list prices were artificially inflated to fund kickbacks for the PBMs in exchange for preferred formulary placement.

753. These Common Law Fraud Defendants intended that Plaintiffs' agent would rely on their misrepresentations and omissions. Through their scheme, PBM Defendants, leveraged formulary control for ever-increasing Manufacturer Payments while the Manufacturer Defendants maintained or increased their profit margins or sales volume as preferred formulary members. Common Law Fraud Defendants intended to profit at the expense of payors like Plaintiffs, through its agents.

754. Plaintiffs and Plaintiffs' agent reasonably relied on these Defendants' deception, and these Common Law Fraud Defendants intended that they would so rely. Plaintiffs and Plaintiffs' agent had no way of discerning that these Common Law Fraud Defendants were, in fact, deceiving them because they possessed exclusive knowledge regarding the nature of diabetes drug pricing; intentionally concealed the foregoing from Plaintiffs, Plaintiffs' agent, and the public; and made

incomplete or false representations about the pricing of the at-issue drugs and their role in that pricing, while purposefully withholding material facts from Plaintiffs and Plaintiffs' agent that contradicted these representations.

755. Plaintiffs and Plaintiffs' agent relied on these Common Law Fraud Defendants' false list prices. Because of the Insulin Pricing Scheme, list prices have skyrocketed and the spread between list price and net price has ballooned in turn. Plaintiffs are injured by this list and net price divergence. Through the scheme, these Common Law Fraud Defendants have forced payors, including Plaintiffs, through its agents, to pay not just for the drugs, but also for undisclosed kickbacks that are paid to PBMs.

756. These Common Law Fraud Defendants took steps to ensure that their employees and co-conspirators did not reveal the details of the Insulin Pricing Scheme to Plaintiffs or Plaintiffs' agent.

757. These Common Law Fraud Defendants owed Plaintiffs a duty to disclose, truthfully, all facts concerning the true cost of the at-issue medications and the inflated and fraudulent nature of their pricing; the existence, amount, flow, and purpose of rebates and discounts negotiated for those products; and the role that Defendants played in increasing the price of the at-issue drugs.

758. These Defendants possessed superior knowledge of essential facts about the at-issue drugs and their prices. That information was peculiarly and

exclusively in their control and not available to payors or their agents, including Plaintiffs and Plaintiffs' agent. In light of their misleading or incomplete representations, these Defendants also had an obligation to disclose facts related to the Insulin Pricing Scheme.

759. These Common Law Fraud Defendants hatched their deceptive schemes and knew that Plaintiffs and Plaintiffs' agent did not know (and could not reasonably discover) that they sought to artificially inflate the price of the insulin medications. These Defendants not only concealed all the facts concerning the true cost of the at-issue medications but went further to make affirmative misrepresentations in marketing materials and other communications that these Defendants worked to lower the ultimate cost of prescription medications. These Defendants engaged in this fraudulent concealment at the expense of Plaintiffs.

760. Plaintiffs and Plaintiffs' agent were not aware of the concealed and misrepresented material facts referenced above, and Plaintiffs would not have acted as it did, had it known the truth.

761. As a direct and proximate result of these Common Law Fraud Defendants' fraudulent scheme, Plaintiffs sustained damages, including but not limited to paying excessive and inflated prices for the at-issue medications.

762. These Common Law Fraud Defendants valued their profits over the trust, health, and safety of Plaintiffs and diabetics across the country. These Defendants repeatedly misrepresented the price of the at-issue drugs.

763. These Common Law Fraud Defendants' actions, misrepresentations, and omissions demonstrate callous disregard for not only the rule of law but also public health. Indeed, as a direct result of these Defendants' actions, access to live-saving diabetes medications has been limited, denied, or forgone.

764. The Common Law Fraud Defendants are liable to Plaintiffs for damages in an amount to be proven at trial. Moreover, because these Defendants acted wantonly, maliciously, oppressively, recklessly, deliberately, and with intent to defraud Plaintiffs and for the purpose of enriching themselves to the public's detriment, Defendants' conduct warrants punitive damages in an amount to be determined at trial.

765. The acts and practices alleged herein are ongoing, repeated, and affect the public interest.

Count VI

Unjust Enrichment Under Pennsylvania and New Jersey Law

(against Defendants Eli Lilly, Novo Nordisk, Sanofi, and CVS Caremark)

766. Plaintiffs re-allege and incorporate by reference all preceding and succeeding factual allegations.

767. Plaintiffs bring this claim against Defendants Eli Lilly, Novo Nordisk, Sanofi, and CVS Caremark. All are referred to collectively throughout the Count as "Count V Defendants."

768. This claim is alleged in the alternative to Plaintiffs'. claims for legal relief.

769. To prevail on a claim for unjust enrichment, one must show that: 1) benefits conferred on defendant by Plaintiffs; 2) appreciation of such benefits by defendant; and 3) retention of such benefits by the defendant under circumstances which are inequitable. *Discovery Bank v. Stucka*, 2011 Pa. Super. 241, 33 A.3d 82 (2011).

770. It is a fundamental principle of fairness and justice that a person should not be unjustly enriched at the expense of another.

771. A person should not be unjustly enriched at the expense of another even if that person's conduct is not tortious.

772. Count V Defendants jointly and severally deceived Plaintiffs and have received a financial windfall from the Insulin Pricing Scheme at Plaintiffs' expense.

773. Plaintiffs, through its agents, conferred a benefit on CVS Caremark by directly purchasing the at-issue insulins, through their agent, from CVS Caremark at artificially and illegally inflated prices as established by the Insulin Pricing Scheme.

774. Plaintiffs, through its agents, unknowingly conferred this benefit upon Defendants to Plaintiffs' financial detriment.

775. Count V Defendants, jointly and severally, wrongfully secured and retained a benefit in the form of amounts paid for diabetes medications, unearned fees and other payments collected based on the market forces and prices generated by the Insulin Pricing Scheme, and revenues that would not have been realized but for the Insulin Pricing Scheme.

776. Count V Defendants, jointly and severally, wrongfully secured and retained a benefit in the form of revenues and profits to which they were not entitled, which did not represent the fair market value of the goods or services they offered, and which were obtained at Plaintiffs' expense.

777. Count V Defendants, jointly and severally, wrongfully secured and retained a benefit in the form of drug monies paid at prices that would not have existed but for Defendants' misconduct.

778. Count V Defendants were aware of the benefit, voluntarily accepted it, and retained and appreciated the benefit, to which they were not entitled, all at Plaintiffs' expense.

779. Because Count V Defendants knew of the benefit unjustly conferred on them by Plaintiffs, through its agents—the purchase of insulin medications at artificially inflated prices—Defendants should have reasonably expected to repay

that benefit to Plaintiffs. Instead, Defendants retained the revenue resulting from the sale of insulin at artificially inflated prices. Any Defendant's retention of any portion of any benefit obtained by way of the Insulin Pricing Scheme is unjust and inequitable regardless of the Insulin Pricing Scheme's legality.

780. Each and every Defendant's retention of any portion of the benefit violates the fundamental principles of justice, equity, and good conscience. Even absent Plaintiffs' ability to prove the elements of any other claim, it would be unfair, unjust, and inequitable for any Defendant to retain any portion of the benefit.

781. Even absent legal wrongdoing by any or all Count V Defendants, Plaintiffs have a better claim to the benefit than any and all Defendants.

782. The benefit retained is in an amount not less than the difference between the reasonable or fair market value of the at-issue drugs for which Plaintiffs paid, through its agents, and the actual value of the at-issue drugs these Count V Defendants delivered and, as to CVS Caremark, the reasonable or fair market value of the services for which Plaintiffs paid, through its agents, and the actual value of services rendered with respect to the at-issue drugs.

783. Count V Defendants should not be permitted to retain the benefit conferred upon them by Plaintiffs, through its agents, and restitution is appropriate to prevent the unjust enrichment.

784. Plaintiffs seek disgorgement of the benefit and seeks restitution, rescission, or such other relief as will restore to Plaintiffs that to which it is entitled.

Count VII

Civil Conspiracy Under Pennsylvania and New Jersey Law

(against all Defendants)

785. Plaintiffs re-allege and incorporate herein by reference each of the allegations from the preceding paragraphs.

786. Defendants' conduct described herein constitutes an agreement between two or more parties to commit an unlawful act or a lawful act by unlawful means and Defendants' overt acts in furtherance of this conspiracy caused Plaintiffs' damages.

787. Defendants aided and abetted one another to violate federal laws and commit common law fraud. Each Defendant planned, assisted, and encouraged the Insulin Pricing Scheme.

788. Each Defendant agreed to and carried out acts in furtherance of the Insulin Pricing Scheme that artificially and egregiously inflated the price of diabetes medications.

789. The PBM Defendants made a conscious commitment to and knowingly participated in the Insulin Pricing Scheme.

790. The Manufacturer Defendants agreed with each other and the PBM

Defendants to intentionally raise their diabetes medication prices and then pay back a significant portion of those prices to the PBMs.

791. In exchange for the Manufacturer Defendants inflating their prices and making large secret payments, the PBM Defendants agreed to and did grant preferred formulary status to the Manufacturer Defendants' diabetes medications.

792. Each Defendant shares a common purpose of perpetuating the Insulin Pricing Scheme and neither the PBM Defendants nor the Manufacturer Defendants alone could have accomplished the Insulin Pricing Scheme without their co-conspirators.

793. The PBM Defendants need the Manufacturer Defendants to inflate the reported price of their diabetes medications and to make secret payments back to the PBM Defendants in order for the PBM Defendants to profit off the Insulin Pricing Scheme.

794. The Manufacturer Defendants need the PBM Defendants to grant their diabetes medications preferred formulary placement in order to maintain access to a majority of payors and diabetics.

795. As discussed throughout this Complaint, the Insulin Pricing Scheme resulted from explicit agreements, direct coordination, constant communication, and exchange of information between the PBMs and the Manufacturers.

796. In addition to the preceding direct evidence of an agreement,

Defendants' conspiracy is also demonstrated by the following indirect evidence that infers Defendants conspired to engage in fraudulent conduct:

- Defendants refuse to disclose the details of their pricing structures, agreements and sales figures in order maintain the secrecy of the Insulin Pricing Scheme;
- Numerous ongoing government investigations, hearings and inquiries have targeted the Insulin Pricing Scheme and the collusion between the Manufacturer and PBM Defendants, including:
  - civil investigation demands from the States of Minnesota, California, Florid, and Washington related to the pricing of their insulin products and their relationships with the PBMs;
  - Letters from numerous senators and representatives in recent years to the Justice Department and the Federal Trade Commission asking them to investigate potential collusion among Defendants;
  - A House Oversight committee investigation into the corporate strategies of drug companies, including Manufacturer Defendants, seeking information on the increasing price of drugs and manufacturers efforts to preserve market share and pricing power;
  - A Senate report titled "Insulin: A Lifesaving Drug Too Often Out of Reach" aimed addressing the dramatic increase in the price of insulin; and
  - Several hearings before both the Senate Financing Committee and the House Oversight and Reform Committees on the Insulin Pricing Scheme and the collusion between the PBMs and the Manufacturers; and
  - Senate Finance Committee's recent two-year probe into the Insulin Pricing Scheme and the conspiracy between the Manufacturers and the PBMs.
- The astronomical rise in the price of the at-issue drugs coincides with PBM Defendants' rise to power within the pharmaceutical pricing system starting in 2003.

797. Plaintiffs were and continue to be damaged by the conspiracy when it overpaid for the diabetes medications as result of Defendants' unlawful actions.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for entry of judgment against the Defendants for all the relief requested herein and to which the Plaintiffs may otherwise be entitled, including:

A. That the Court determine that Defendants have violated RICO, the Pennsylvania Deceptive and Unfair Trade Practices Act, New Jersey Consumer Fraud Act, committed common law fraud, have been unjustly enriched, and engaged in a civil conspiracy;

B. Judgment in favor of Plaintiffs and against the Defendants for damages in excess of the minimum jurisdictional requirements of this Court, in a specific amount to be proven at trial;

C. That Plaintiffs be granted the following specific relief: In accordance with UTPCPL, that Defendants, their affiliates, successors, transferees, assignees, and the officers, directors, partners, agents, and employees thereof, and all other persons acting or claiming to act on their behalf or in concert with them, be enjoined and restrained from in any manner continuing, maintaining, or renewing the conduct, contract, conspiracy, or combination alleged herein in violation of Pennsylvania law, New

Jersey law and RICO, or from entering into any other contract, conspiracy, or combination having a similar purpose or effect, and from adopting or following any practice, plan, program or device having a similar purpose or effect;

D. That Plaintiffs:

i. be awarded treble damages pursuant to 18 U.S.C. § 1964(c);

ii. be awarded restitution, damages, disgorgement, penalties and/or all other legal and equitable monetary remedies available under the state laws set forth in this Complaint, and the general equitable powers of this Court in an amount according to proof;

iii. be awarded punitive damages because Defendants knowingly, willfully, wantonly and intentionally harmed the health, wellbeing, and financial interests Plaintiffs and their Beneficiaries;

iv. be awarded pre- and post-judgment interest as provided by law, and that such interest be awarded at the highest legal rate from and after the date of service of the initial complaint in this action;

v. recover costs of suit, including its reasonable attorney's fees, as provided by law and pursuant to Pennsylvania Law, New Jersey Law and 18 U.S.C § 1964(c); and

vi. be awarded such other, further, and different relief as the case may require and the Court may deem just and proper under the circumstances.

vii. be awarded damages, treble damages, statutory damages and punitive damages, where applicable.

JURY DEMAND

Plaintiffs demand trial by jury on all issues so triable.

Date: December 30, 2025

Respectfully submitted,

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