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VIRGINIA: IN THE CIRCUIT COURT FOR THE CITY OF RICHMOND

COMMONWEALTH OF VIRGINIA, *EX REL.* JASON S. MIYARES, ATTORNEY GENERAL,

PLAINTIFF,

V.

EVERNORTH HEALTH, INC. (FORMERLY EXPRESS SCRIPTS HOLDING COMPANY); EXPRESS SCRIPTS, INC.; EXPRESS SCRIPTS ADMINISTRATORS, LLC; ESI MAIL PHARMACY SERVICE, INC.; EXPRESS SCRIPTS PHARMACY, INC.; MEDCO HEALTH SOLUTIONS, INC.; CVS HEALTH CORPORATION; CVS PHARMACY, INC.; CAREMARK RX, L.L.C.; CAREMARKPCS HEALTH, L.L.C.; CAREMARK, L.L.C.; UNITEDHEALTH GROUP, INC.; OPTUMINSIGHT, INC.; OPTUMRX INC.; SANOFI-AVENTIS U.S. LLC; AND NOVO NORDISK INC.;

DEFENDANTS.

Case No. _____

COMPLAINT

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Plaintiff, Commonwealth of Virginia ("Commonwealth" or "Plaintiff"), by, through and at the relation of the Attorney General, Jason S. Miyares, petitions this Court to declare that the activities in which the Defendants have engaged constitute violations of the Virginia Consumer Protection Act ("VCPA"), Virginia Code §§ 59.1-196 through 59.1-207; to enjoin these violations; to restore to consumers the sums acquired from them in violation of the VCPA; to award civil penalties, costs, expenses, and attorney's fees to the Commonwealth; to grant disgorgement and other equitable relief as necessary to remedy the unlawful conduct of Defendants; and to otherwise grant such relief as is necessary to address the acts of Defendants as set forth in this Complaint.

I. INTRODUCTION

1. Diabetes is an epidemic and a public health crisis in Virginia. Virginia has a high prevalence of diabetes, with approximately 11% of its population—hundreds of thousands of people—living with diabetes. Over 2 million Virginia residents have prediabetes, which is when a person's blood sugar level is higher than it should be and signifies that the person is at greater risk for developing diabetes.[1]

2. Diabetes is a leading cause of blindness, kidney failure, and lower limb amputations and is a leading cause of death in Virginia despite the availability of effective treatment.[2]

[1] VIRGINIA HEALTH DEP'T, *Diabetes and Prediabetes Data*, https://www.vdh.virginia.gov/diabetes/data/ (last visited Dec. 17, 2025).

[2] VIRGINIA HEALTH DEP'T, *Diabetes in Virginia* (Dec. 2016) https://www.vdh.virginia.gov/content/uploads/sites/75/2016/12/Diabetes-Burden-Report.pdf.

3. The economic impact of diabetes is profound. The total estimated cost of diagnosed diabetes in Virginia is $8.4 billion per year. And a substantial portion of health care dollars are spent caring for people with diabetes.[3]

4. Nearly all diabetics in Virginia rely on daily insulin treatments, Type 2 diabetic treatments such as glucagon-like peptide (GLP-1) drugs, or a combination of both to treat and control their diabetes.

5. Defendants Novo Nordisk and Sanofi (collectively, "Manufacturer Defendants" or "Manufacturers")—alongside one additional insulin manufacturer—manufacture the vast majority of insulins and other diabetic medications available in Virginia.

6. Defendants Express Scripts, CVS Caremark, and OptumRx ("PBM Defendants" or "PBMs") collectively dominate the pricing system for the at-issue drugs.[4]

7. Their dominance results from the reality that these three corporate actors are, at once: (a) the largest pharmacy benefit managers in the United States and in Virginia (controlling approximately 80% of the PBM market); and (b) the largest pharmacies in the United States and in Virginia (making up 3 of the top 5 dispensing pharmacies in the U.S.).

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[3] AM. DIABETES ASS'N, *The Burden of Diabetes in Virginia* (Sept. 2023) https://diabetes.org/sites/default/files/2023-09/ADV_2023_State_Fact_sheets_all_rev_Virginia.pdf.

[4] In the context of this Complaint, the "at-issue drugs" are Lantus, Toujeo, Apidra, Soliqua, Xultophy, Rybelsus, Adlyxin, Novolin R, Novolin N, Novolog, Levemir, Tresiba, Victoza, and Ozempic.

8. These PBM conglomerates sit at 3rd (OptumRx), 5th (CVS Caremark), and 13th (Express Scripts) on the Fortune 500 list ranking largest corporations by revenue.

9. Because of their size and the roles their affiliated entities play in the pharmaceutical system, CVS Caremark, OptumRx, and Express Scripts have near-complete control of the pricing, dispensing, and reimbursement systems for the at-issue diabetes medications for their covered lives.[5] The PBM Defendants affect nearly every diabetic drug transaction in Virginia.

10. While the PBM Defendants represent that they perform their services on behalf of their clients and diabetics to lower drug prices, increase access to affordable drugs, and promote diabetic health, these representations are false.

11. Rather, the PBM Defendants have worked in coordination with the Manufacturer Defendants to distort the market for diabetic treatments to their benefit at the expense of Virginia diabetics.

12. As part of their work, PBM Defendants establish standard formulary offerings. Drug formularies are tiered lists which determine which drugs are available, at what out-of-pocket costs, and with what restrictions for insured consumers. If a drug is not included on a formulary, then it is not covered by health insurance.

13. PBM Defendants understand that their standard formulary offerings drive drug utilization and price.

[5] "Covered lives" refer to patients that are enrolled in health plans covered by a PBM.

14. Because the three PBM Defendants control 80% of the pharmacy benefit market, unless they include a drug on one of their standard formulary offerings, it is not available to 80% of Virginia's citizens.

15. The Manufacturers likewise understand that PBMs' standard formularies drive drug utilization—if Manufacturers want their drugs to be prescribed and paid for, they must obtain preferrable formulary position on the PBM Defendants' formularies.

16. Given the PBMs' market power and the crucial role their standard formularies play in the pharmaceutical pricing chain, both Defendant groups understand that the PBM Defendants wield enormous control over drug prices and drug purchasing behavior.

17. The unlawful and deceptive scheme at the root of this Complaint—the Insulin Pricing Scheme—was born from this mutual understanding

18. Over the course of approximately the last fifteen years, and pursuant to the Insulin Pricing Scheme, Manufacturer Defendants have in lockstep raised the prices of their respective diabetes drugs despite the fact that the cost to produce these drugs has decreased during that same time period.

19. Insulins, which today cost Manufacturer Defendants less than $2 to produce and which were originally priced at $20 when released in the late 1990s, increased to prices ranging between $300 and $700 by the late the 2019s.

20. In the last decade alone, Manufacturer Defendants have in tandem increased the prices of their diabetes medications up to 1000%, often down to the decimal point within a few days of each other.

21. Remarkably, nothing about these medications has changed; more recent $350 insulin is the exact drug Defendants originally sold for $20.

22. The current unlawfully-inflated price stands in stark contrast to insulin's origins. The discoverers sold the original patent for $1 to ensure that the medication would remain affordable. Today, insulin has become the poster child for inflated drug prices.

23. Both Manufacturer and PBM Defendants play vital roles and profit immensely from the Insulin Pricing Scheme and the artificially-inflated prices produced by it.

24. Specifically, the Insulin Pricing Scheme works as follows: first, to gain formulary access from the PBM Defendants for their diabetic treatments, Manufacturer Defendants artificially and willingly raise their list prices, and then pay a significant, yet undisclosed, portion of that price back to the PBMs.

25. These Manufacturer Payments[6] are provided under a variety of labels; yet, however they are described, these Manufacturer Payments, along with the

[6] In the context of this Complaint, the term "Manufacturer Payments" is defined as all payments or financial benefits of any kind conferred by the Manufacturer Defendants to PBM Defendants (or a subsidiary, affiliated entity, or group purchasing organization or rebate aggregator acting on the PBM's behalf), either directly via contract or indirectly via Manufacturer-controlled intermediaries. Manufacturer Payments include rebates, administrative fees, inflation fees, pharmacy supplemental discounts, volume discounts, price or margin guarantees, price concessions, indirect purchase fees and rebates, and any other form of consideration exchanged. This broad definition is necessary because PBMs historically have continued to change and evolve the nature of their payment streams to avoid

inflated list prices, are *quid pro quo* for formulary inclusion on the PBMs' standard offerings.

26. The list prices for the at-issue drugs have become so untethered from the net prices realized by the Manufacturers as to constitute a false or misleading price.

27. PBMs then grant preferred status on their standard formularies based upon the largest Manufacturer Payment and the highest inflated list price—which the PBMs know to be artificially-inflated, and which the PBMs insist that their payor clients and diabetics use as the basis for the price they pay for the at-issue drugs.

28. To make matters worse, rather than pass on these Manufacturer Payments to diabetics or their clients to lower the prices, the PBM Defendants instead obfuscate and retain significant amounts of these Manufacturer Payments as profit.

29. Moreover, around 2012, PBM Defendants began to implement a bold new formulary strategy by creating so-called "exclusionary" formularies which entirely exclude (i.e. do not cover or list) one or more drugs used to treat the same condition.

30. The PBM Defendants created exclusionary formularies to further drive up their own profits.

31. In order to maintain their profit margins, the Manufacturer Defendants further raised their list prices in order to make larger and larger Manufacturer Payments to the PBM Defendants.

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disclosure to clients and disclosure pursuant to state transparency laws. While the route by which the payment streams reach the PBMs has evolved, the fact that the payments do, in fact, reach the PBMs has remained the same.

32. As a result of exclusionary formularies, the PBM Defendants were then able to significantly increase the amount of Manufacturer Payments that they were receiving from the Manufacturer Defendants.

33. The Insulin Pricing Scheme creates a "best of both worlds" scenario for Defendants. Manufacturer Defendants are able to make these undisclosed Manufacturer Payments to buy preferred formulary position—which significantly increases their revenue and protects their market share—without sacrificing their profits.

34. For the PBM Defendants—contrary to their representations—they make more money from diabetic drugs with higher list prices and higher Manufacturer Payment amounts.

35. In particular, the PBM Defendants profit off of the inflated list prices that result from the Insulin Pricing Scheme in numerous ways, including: (a) retaining a significant—yet undisclosed—percentage of the Manufacturer Payments, either directly or through wholly owned rebate aggregators; (b) using the inflated list price produced by the Insulin Pricing Scheme to generate profits from pharmacies in their networks and (c) relying on those same inflated list prices to drive up the PBMs' profits through their own pharmacies.

36. The PBM Defendants steer their clients' prescription-drug plans to their affiliated pharmacies, including Defendant CVS Pharmacy (and the PBM Defendants' affiliated mail order pharmacies), and then overcharge for the at-issue drugs dispensed at those pharmacies to further profit from the Insulin Pricing Scheme.

37. PBM Defendants also collect additional Manufacturer Payments (again tied to list price) from the Manufacturer Defendants for the at-issue drugs sold through their captive pharmacies.

38. Thus, while the PBM Defendants represent both publicly and to their clients that they use their market power to drive down prices for diabetes medications, these representations are false and intended to be deceptive and misleading.

39. Rather, the PBMs are intentionally driving up the price of the at-issue drugs. Indeed, the Manufacturer Payments the PBMs receive in exchange for preferred formulary position, along with the PBMs' actual formulary construction, are directly responsible for price increases of the at-issue diabetes medications.

40. Because the PBM Defendants control which drugs are available for the vast majority of Virginia diabetics, and because the price paid by nearly every diabetic and payor is based upon the artificially-inflated list prices generated by Defendants' scheme, the Insulin Pricing Scheme directly harms every diabetic in Virginia who purchase these life-sustaining drugs.

41. The consequences to Virginia public health and Virginia's diabetic consumers from the substantial price increases caused by the Insulin Pricing Scheme cannot be overstated.

42. Virginia diabetics have been overcharged millions of dollars a year in out-of-pocket costs as a result of the Insulin Pricing Scheme.

43. Further, the Insulin Pricing Scheme and the PBM Defendants' formulary exclusions have cut off access for Virginia diabetics to lower priced, affordable diabetic treatments.

44. For Virginia diabetics, the physical, emotional, and financial tolls of paying such excessive prices for diabetes medications is devastating. Unable to afford the drugs their doctors prescribe, diabetics in Virginia ration or under-dose their insulin; inject expired insulin; reuse needles; and starve themselves to control their blood sugars. This behavior is extremely dangerous and has led to serious complications or even death.

45. On January 14, 2021, the US Senate Finance Committee released a Staff Report titled "Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug" ("January 2021 Senate Insulin Report"). This report was the culmination of a two-year investigation that produced hundreds of thousands of pages of confidential Manufacturer and PBM documents.[7]

46. For the first time, these confidential documents revealed key information demonstrating that it was the Defendants' misconduct in furtherance of the Insulin Pricing Scheme that was the driving force behind the precipitous price increases for diabetes medications.

47. A year after the release of the January 2021 Senate Insulin Report, the Federal Trade Commission ("FTC") began an investigation into PBM Defendant

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

practices ("PBM FTC Inquiry"). In its policy statement announcing this investigation, the FTC cited specifically the effect that Manufacturer Payments have in the context of high insulin prices and the devastating impact such practices have on the lives of diabetics.

48. Following this investigation, on September 20, 2024, the FTC brought an action against PBM Defendants and their affiliated rebate aggregators (Ascent, Emisar, Zinc) for engaging in the Insulin Pricing Scheme.[8]

49. This Complaint centers on Defendants' violations of the Virginia Consumer Protection Act and seeks injunctive relief, restitution, disgorgement, statutory civil penalties, costs, expenses, and attorneys' fees to address the harm caused by the Insulin Pricing Scheme.

50. The relevant period for the relief requested and the activities alleged in this Complaint is from 2003 continuing through the present.

II. PARTIES

A. Plaintiff

51. **Plaintiff, the Commonwealth of Virginia**. The Plaintiff, the Commonwealth of Virginia *ex rel*. Jason S. Miyares, Attorney General, is charged with enforcing the VCPA, which prohibits fraudulent or deceptive acts or practices made by a supplier in connection with a consumer transaction. Pursuant to Virginia Code § 59.1-203, the Attorney General may initiate civil law enforcement proceedings in the

[8] *Complaint, In the Matter of Caremark Rx, LLC, et al*, No. 9437 (FTC), https://www.ftc.gov/system/files/ftc_gov/pdf/d9437_caremark_rx_zinc_health_services_et_al_part_3_complaint_corrected_public.pdf

name of the Commonwealth to enjoin violations of the VCPA and to secure such equitable and other relief as may be appropriate in each case.

B. PBM Defendants

52. **Defendant Evernorth Health, Inc. ("Evernorth"),** formerly known as Express Scripts Holding Company, is a Delaware corporation with its principal place of business at 1 Express Way, St. Louis, Missouri 63121.[9]

53. Evernorth may be served through its registered agent: The Corporation Trust Company, Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware 19801.

54. Evernorth, through its executives and employees is directly involved in shaping the company policies that inform its PBM services and formulary construction, including with respect to the at-issue drugs, related to the Insulin Pricing Scheme.

55. For example, during the relevant time period Evernorth's CEO Tim Wentworth was involved in communications with the Manufacturer Defendants related to the at-issue drugs and at-issue Manufacturer Payments.

56. Evernorth's conduct has had a direct effect in Virginia and harmed diabetics in Virginia.

[9] 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.

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

58. Throughout the relevant time period, the Manufacturer Defendants directly engaged with Evernorth executives in furtherance of the Insulin Pricing Scheme. Each Manufacturer Defendant has an entire team of executives dedicated exclusively to interacting with Evernorth.

59. Manufacturers recognize that effectuating the Insulin Pricing Scheme requires relationships at C-Suite level between the Manufacturers and Evernorth to maximize each company's opportunities.

60. On a regular basis throughout the relevant time period, these Manufacturer executive teams—which at times include the CEOs from these companies—met with Evernorth to discuss their coordinated efforts related to the at-issue drugs. For example, in at least 2013 and 2014, the leaders of Evernorth and Novo Nordisk participated in executive meetings which appear to have included discussions in furtherance of the Insulin Pricing Scheme.

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

62. In December 2018, Evernorth merged with Cigna in a $67 billion deal to 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 utilized by approximately 15 million Cigna members in the United States and in Virginia. Evernorth controls the entire drug pricing chain for these 15 million Americans.

63. In each annual report for at least a decade, Evernorth has repeatedly, continuously, and explicitly stated:[10]

a. "[Evernorth] is one of the largest PBMs in North America . . . [and Evernorth] help[s] health benefit providers address access and affordability concerns resulting from rising drug costs while helping to improve healthcare outcomes."

b. "[Evernorth] manage[s] the cost of the drug benefit by . . . assisting in controlling costs; evaluat[ing] drugs for efficacy, value and price to assist clients in selecting a cost-effective formulary; [and] offer[ing] cost-effective home delivery pharmacy and specialty services that result in cost savings for plan sponsors [and better care for members] leveraging purchasing volume to deliver discounts to health benefit providers."

c. "[Evernorth] 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."

[10] Express Scripts Annual Reports (Form 10-K) (Dec. 31, 2009-2019).

64. **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.

65. Express Scripts, Inc. has a certificate of authority to and transacts business in Virginia and may be served through its registered agent: CT Corporation System, 4701 Cox Road Suite 285, Glen Allen, VA 23060.

66. Express Scripts, Inc. is the immediate or indirect parent of pharmacy and PBM subsidiaries that operate throughout Virginia that engaged in the conduct, which gave rise to this Complaint.

67. During the relevant time period, Express Scripts Inc. was directly involved in the PBM and mail order pharmacy services, which gave rise to the Insulin Pricing Scheme and harmed diabetics in Virginia.

68. **Defendant Express Scripts Administrators, 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 the same location as Evernorth.

69. Express Scripts Administrators, LLC has a certificate of authority to and transacts business in Virginia and may be served through its registered agent: CT Corporation System, 4701 Cox Road Suite 285, Glen Allen, VA 23060.

70. During the relevant time period, Express Scripts Administrators, LLC provided the PBM services in Virginia discussed in this Complaint that gave rise to the Insulin Pricing Scheme that harmed diabetics in Virginia.

71. **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 at the same location as Evernorth.

72. ESI Mail Pharmacy Service, Inc. may be served through its registered agent: CT Corporation System, 4701 Cox Road, Suite 285, Glen Allen, VA 23060.

73. ESI Mail Pharmacy Service, Inc. holds active licenses with the Virginia Board of Pharmacy.

74. During the relevant time period, ESI Mail Pharmacy Services provided the mail order pharmacy services in Virginia discussed in this Complaint, which gave rise to the Insulin Pricing Scheme and harmed diabetics in Virginia.

75. **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.

76. Express Scripts Pharmacy, Inc. may be served through its registered agent: CT Corporation System, 4701 Cox Road Suite 285, Glen Allen, VA 23060.

77. Express Scripts Pharmacy, Inc. holds active licenses with the Virginia Board of Pharmacy.

78. During the relevant time period, Express Scripts Pharmacy, Inc. provided the mail order pharmacy services in Virginia discussed in this Complaint, which gave rise to the Insulin Pricing Scheme and harmed diabetics in Virginia.

79. **Defendant Medco Health Solutions, Inc. ("Medco")** is a Delaware Corporation with its principal place of business located at 100 Parsons Pond Road, Franklin Lakes, New Jersey.

80. Medco may be served through its registered agent: CT Corporation System, 4701 Cox Road Suite 285, Glen Allen, VA 23060.

81. Prior to 2012, Medco provided the at-issue PBM and mail order services in Virginia, which gave rise to the Insulin Pricing Scheme and harmed diabetics in Virginia.

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

83. Prior to the merger, Express Scripts and Medco were two of the largest PBMs in the United States and in Virginia.

84. Prior to the merger, Medco provided the at-issue PBM and mail-order services in Virginia, which gave rise to the Insulin Pricing Scheme and harmed diabetic Virginians.

85. 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) continued under the name Express Scripts with all of Medco's payor customers becoming Express Scripts' customers. The combined company covered over 155 million individuals at the time of the merger.

86. At the time of the merger, on December 6, 2011, in his testimony before the Senate Judiciary Committee, then CEO of Medco, David B. Snow, publicly represented 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 [Manufacturer Payments] from drug manufacturers and other suppliers."[11]

87. The then-CEO of Express Scripts, George Paz, during a Congressional subcommittee hearing in September 2011, echoed these sentiments: "A combined Express Scripts and Medco will be well-positioned to protect American families from the rising cost of prescription medicines."[12]

88. As a result of numerous interlocking directorships and shared executives, Evernorth and Express Scripts, Inc. are directly involved in the conduct of and control Express Scripts Administrators, LLC, Medco Health Solutions, Inc., ESI Mail Pharmacy Service, Inc., and Express Scripts Pharmacy, Inc.'s operations, management and business decisions related to the at-issue formulary construction, Manufacturer Payments, and mail order pharmacy services to the ultimate detriment of Virginia diabetics.

89. For example, during the relevant time period, these parents and subsidiaries have had common officers and directors:

a. Officers and/or directors that have been shared between Express Scripts, Inc. and Evernorth include Bradley Phillips, Chief

[11] *Hearing on the Proposed Merger between Express Scripts and Medco before the S. Comm. On the Judiciary*, 112-54, (Dec. 6, 2011), available at https://www.judiciary.senate.gov/committee-activity/hearings/the-express-scripts/medco-merger-cost-savings-for-consumers-or-more-profits-for-the-middlemen-2011-12-06; *The Proposed Merger Between Express Scripts and Medco: Hearing Before the H. Comm. On the Judiciary*, 112-58, (Sept. 20, 2011), available at https://www.congress.gov/112/chrg/CHRG-112hhrg68401/CHRG-112hhrg68401.pdf.

[12] *Id.*

Financial Officer; David Queller, President; Jill Stadelman, Secretary; Timothy Smith, Vice President; and Scott Lambert, Treasury Manager Director;

b. Executives that have been shared between Express Scripts Administrators, LLC and Evernorth include Bradley Phillips, Chief Financial Officer; and Priscilla Duncan, Associate Secretary;

c. Officers and/or directors that have been shared between ESI Mail Pharmacy Service, Inc. and Evernorth include Bradley Phillips, Chief Financial Officer; Priscilla Duncan, Associate Secretary; and Joanne Hart, Associate Treasurer;

d. Officers and/or directors that have been shared between Express Scripts Pharmacy, Inc. and Evernorth include Bradley Phillips, Chief Financial Officer; Jill Stadelman, Secretary; Scott Lambert, Treasury Manager Director; and Joanne Hart, Associate Treasurer; and

e. Officers and/or directors that have been shared between Medco Health Solutions, Inc. and Evernorth include David Queller, President and Senior VP of Sales & Accounting, Christine Houston, VP and COO, Timothy Smith, VP and Treasurer; and all of the officers of Medco Health Solutions are also officers of Express Scripts, Inc.

90. Evernorth directly or indirectly owns all the stock of Express Scripts Administrators, LLC, Medco Health Solutions, Inc., ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc. and Express Scripts, Inc.

91. The Evernorth corporate family does not operate as separate entities. The public filings, documents, and statements of Evernorth presents its subsidiaries, including Express Scripts Administrators, LLC, Medco Health Solutions, Inc., ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc., and Express Scripts, Inc. 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."

92. The day-to-day operations of this corporate family reflect these public statements. All of these entities are a single business enterprise and should be treated as such as to all legal obligations detailed in this Complaint. The Evernorth enterprise and each of these entities, both individually and collectively, engaged in the at-issue conduct that gave rise to the Insulin Pricing Scheme.

93. All of the executives of Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Medco Health Solutions, Inc., Express Scripts Pharmacy, Inc., and Express Scripts, Inc. ultimately report to the executives, including the CEO, of Evernorth.

94. As stated above, Evernorth's CEO and other executives and officers are directly involved in the policies and business decisions of Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Medco Health Solutions, Inc.,

Express Scripts Pharmacy, Inc., and Express Scripts, Inc. that gave rise to the Commonwealth's claims in this Complaint.

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

96. Express Scripts is named as a Defendant in its capacities as a PBM and mail order pharmacy.

97. In its capacity as a PBM, Express Scripts coordinates with Novo Nordisk and Sanofi regarding the artificially-inflated list prices for the at-issue diabetes medications, as well as for the placement of these firms' diabetes medications on Express Script's formularies.

98. Prior to merging with Cigna in 2019, Express Scripts was the largest independent PBM in the United States. During the relevant period of this Complaint, Express Scripts controlled 30% of the PBM market in the United States.

99. Express Scripts has only grown larger since the Cigna merger.

100. In 2017, annual revenue for Express Scripts was over $100 billion.

101. As of December 31, 2018, more than 68,000 retail pharmacies, representing over 98% of all retail pharmacies in the nation, participated in one or more of Express Scripts' networks.

102. At all times relevant hereto, Express Scripts offered pharmacy benefit services, and derived substantial revenue therefrom, in Virginia and provided the at-issue PBM services to numerous payors in Virginia.

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

104. At all times relevant hereto, Express Scripts has concealed its critical role in the generation of those artificially-inflated list prices.

105. At all times relevant hereto, Express Scripts constructed standard formularies that are used nationwide, including by Express Scripts' payor clients in Virginia, and that are relied on by consumers in Virginia with diabetes as promoting diabetic health and lowering the price of the at-issue drugs. During the relevant time period, these standard formularies included the at-issue diabetes medications.

106. During certain years when some of the largest at-issue price increases occurred, including in 2013 and 2014, Express Scripts worked directly with OptumRx to negotiate Manufacturer Payments on behalf of OptumRx and its clients in exchange for preferred formulary placement.

107. For example, in a February 2014 email released by the U.S. Senate in conjunction with the January 2021 Senate Insulin Report, describes a "Russian nested doll situation" in which Express Scripts was negotiating rebates on behalf of

OptumRx related to the at-issue drugs for Cigna (who later would become part of Express Scripts).

108. In its capacity as a mail order pharmacy, Express Scripts dispensed the at-issue drugs to Virginia diabetics and received payments from Virginia diabetics and payors based on the artificially-inflated prices produced by the Insulin Pricing Scheme and, as a result, harmed Virginia diabetics.

109. At all times relevant hereto, Express Scripts derived substantial revenue providing mail order pharmacy services in Virginia.

110. Express Scripts purchases drugs produced by the Manufacturer Defendants, including the at-issue diabetes medications, for dispensing through its mail order pharmacies.

111. At all times relevant hereto, Express Scripts had express agreements with Defendants Novo Nordisk and Sanofi related to the Manufacturer Payments paid to Express Scripts and placement on Express Scripts' standard formularies, as well as agreements related to the Manufacturers' at-issue drugs sold through Express Scripts' mail order and retail pharmacies, including those located in Virginia.

112. **Defendant CVS Health Corporation ("CVS Health")** is a Delaware corporation with its principal place of business at One CVS Drive, Woonsocket, Rhode Island 02895. CVS Health transacts business and has locations throughout the United States and Virginia.

113. CVS Health may be served through its registered agent: The Corporation Trust Company, Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware 19801.

114. CVS Health, through its executives and employees, including its CEO, Chief Medical Officer, Executive Vice Presidents, Senior Executives in Trade Finance, and Chief Communication Officers, is directly involved in the PBM services and formulary construction related to the Insulin Pricing Scheme that gave rise to the Commonwealth's claims.

115. During the relevant time, CVS Health (or its predecessor)[13] has repeatedly, continuously, and explicitly stated that CVS Health*:*

a. "design[s] pharmacy benefit plans that minimize the costs to the client while prioritizing the welfare and safety of the clients' members and helping improve health outcomes;"[14]

b. "negotiate[s] with pharmaceutical manufacturers to obtain discounted acquisition costs for many of the products on [CVS Health's] drug lists, and these negotiated discounts enable [CVS Health] to offer reduced costs to clients;"[15]

[13] Until 2014, CVS Health was known as "CVS Caremark." In September 2014, "CVS Caremark Corporation announced that it is changing its corporate name to CVS Health to reflect its broader health care commitment and its expertise in driving the innovations needed to shape the future of health."

[14] CVS Caremark/CVS Health, Annual Reports (Form 10-K) (Dec. 31, 2009-2019).

[15] CVS Caremark/CVS Health, Annual Reports (Form 10-K) (Dec. 31, 2009-2013).

c. "utilize[s] 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 [CVS Health's] drug lists."[16]

116. CVS Health publicly represents that CVS Health constructs programs that lower the cost of the at-issue diabetes medications. For example, in 2016, CVS Health announced a new program to "reduce overall spending in diabetes" that is available in all states, including Virginia, 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 $3000 to $5000 per year for each member who successfully improves control of their diabetes" (emphasis supplied).[17]

117. In 2017, CVS Health stated that "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."[18]

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[16] CVS Caremark/CVS Health, Annual Reports (Form 10-K) (Dec. 31, 2009-2019).

[17] *CVS Health Introduces New "Transform Diabetes Care" Program to Improve Health Outcomes and Lower Overall Health Care Costs*, PR NEWSWIRE (Dec. 13, 2016), https://www.prnewswire.com/news-releases/cvs-health-introduces-new-transform-diabetes-care-program-to-improve-health-outcomes-and-lower-overall-health-care-costs-300377101.html.

[18] *Current and New Approaches to Making Drugs More Affordable*, CVS HEATH (Aug. 2018), https://www.cvshealth.com/content/dam/enterprise/cvs-enterprise/pdfs/ingestion/cvs-health-current-and-new-approaches-to-making-drugs-more-affordable.pdf.

118. Throughout the relevant time period, the Manufacturer Defendants directly engaged with CVS Health executives in furtherance of the Insulin Pricing Scheme. Each Manufacturer Defendant has an entire team of executives dedicated exclusively to interacting with CVS Health.

119. Manufacturer Defendants have explicitly recognized that effectuating the Insulin Pricing Scheme required intimacy and connection between the Manufacturer Defendants' leaders and CVS Health's leaders in order to align on strategic formulary management initiatives.

120. On a regular basis throughout the relevant period, the Manufacturer Defendants' executive teams—which at times included their CEOs—met with CVS Health executives to discuss their coordinated efforts related to the at-issue drugs. Examples include:

a. In at least 2011, 2012, 2014, and 2016 the leaders of CVS Health and Novo Nordisk participated in executive exchange meetings, which appear to have included discussions in furtherance of the Insulin Pricing Scheme. These meetings included the Executive Vice President of CVS Health, the Chief Medical Officer of CVS Health (Dr. Troy Brennan), members of CVS Health's Enterprise Operating Committee (Matthew Leonard) and key executives from Novo Nordisk.

b. In at least 2012 and 2016, the leaders of CVS Health and Sanofi participated in executive meetings which included discussions in

furtherance of the Insulin Pricing Scheme. These meetings included the CEO of CVS Health, the COO of CVS Health and members of CVS Health's Enterprise Operating Committee, among others.

121. In November 2018, CVS Health acquired Aetna for $69 billion and became the first combination of a major health insurer, PBM, mail order and retail pharmacy chain. As a result, CVS Health controls the health plan/insurer, the PBM and the pharmacies utilized by approximately 40 million Aetna members in the United States and in Virginia. CVS Health controls the entire drug pricing chain for these 40 million Americans.

122. **Defendant CVS Pharmacy, Inc. ("CVS Pharmacy")** is a Rhode Island corporation whose principal place of business is at the same location as CVS Health. CVS Pharmacy is a wholly-owned subsidiary of CVS Health.

123. CVS Pharmacy owns and operates hundreds of pharmacies throughout Virginia that were directly involved in and profited from the Insulin Pricing Scheme.

124. In its capacity as a retail pharmacy, CVS Pharmacy, working in conjunction with its corporate affiliate entities, knowingly assisted the CVS Health family in profiting from the artificially-inflated list prices produced by the Insulin Pricing Scheme by pocketing the spread between acquisition cost for the drugs at issue (an amount well below the list price generated by the Insulin Pricing Scheme), and the amounts received from payors (which amounts were based on the artificially-

inflated list prices and, in many cases, were set by CVS Caremark in its capacity as a PBM).

125. CVS Pharmacy is the immediate and direct parent of Defendant Caremark Rx, L.L.C.

126. CVS Pharmacy has a certificate of authority to and transacts business in Virginia and may be served through its registered agent: CT Corporation System, 4701 Cox Road, Suite 285, Glen Allen, VA 23060.

127. CVS Pharmacy holds three active licenses with the Virginia Board of Pharmacy.

128. During the relevant time period, CVS Pharmacy provided retail pharmacy services in Virginia that gave rise to the Insulin Pricing Scheme, which harmed Virginia diabetics.

129. **Defendant Caremark Rx, L.L.C.** is a Delaware limited liability company and its principal place of business is at the same location as CVS Pharmacy and CVS Health.

130. Caremark Rx, L.L.C. is a wholly owned subsidiary of Defendant CVS Pharmacy.

131. Caremark Rx, L.L.C. may be served through its registered agent: The Corporation Trust Company, Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware 19801.

132. During the relevant time period, Caremark Rx, L.L.C. provided PBM and mail order pharmacy services in Virginia that gave rise to the Insulin Pricing Scheme and harmed diabetics in Virginia.

133. **Defendant CaremarkPCS Health, L.L.C.** is a Delaware limited liability company whose principal place of business is at the same location as CVS Health. CVS Health is the direct or indirect parent company of CaremarkPCS Health LLC.

134. CaremarkPCS Health, L.L.C. provides pharmacy benefit management services.

135. CaremarkPCS Health, L.L.C. has a certificate of authority to and transacts business in Virginia and may be served through its registered agent: CT Corporation System, 4701 Cox Road Suite 285, Glen Allen, VA 23060.

136. During the relevant time period, CaremarkPCS Health, L.L.C. provided PBM services in Virginia, which gave rise to the Insulin Pricing Scheme and harmed diabetics in Virginia.

137. **Defendant Caremark L.L.C.** is a California limited liability company whose principal place of business is at the same location as CVS Health. Caremark, L.L.C. is a wholly owned subsidiary of Caremark Rx, L.L.C.

138. Caremark, L.L.C. has a certificate of authority to and transacts business in Virginia and may be served through its registered agent: CT Corporation System, 4701 Cox Road, Suite 285, Glen Allen, VA 23060.

139. During the relevant time period, Caremark, L.L.C. provided PBM and mail order pharmacy services in Virginia that gave rise to the Insulin Pricing Scheme, which harmed diabetics in Virginia

140. As a result of numerous interlocking directorships and shared executives, Caremark Rx, L.L.C., CVS Pharmacy, and CVS Health are directly involved in the conduct of and control CaremarkPCS Health, L.L.C and Caremark, L.L.C.'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 diabetics in Virginia.

141. For example, during the relevant time period, these parent and subsidiaries have had common officers and directors. Examples include:

a. Thomas S. Moffatt was Vice President and Secretary of Caremark Rx, L.L.C., CaremarkPCS Health L.L.C., and Caremark, L.L.C at the same time he was a Vice President, Assistant Secretary, and Assistant General Counsel at CVS Health and Director, Vice President, and Secretary at CVS Pharmacy;

b. Melanie K. Luker was the Assistant Secretary of CVS Pharmacy, Caremark Rx, L.L.C., CaremarkPCS Health, L.L.C, and Caremark, L.L.C. at the same time she was a Senior Manager of Corporate Services at CVS Health;

c. Jonathan C. Roberts was an Executive Vice President and Chief Operating Officer at CVS Health at the same time he was CEO of Caremark Rx, L.L.C.;

d. Daniel P. Davison was the President of CaremarkPCS Health LLC at the same time he was a Senior Vice President at CVS Health;

e. Annie E. Klis was a Vice President at CVS Health at the same time she was CEO of Caremark, L.L.C.

f. CVS Health directly or indirectly owns all the stock of CVS Pharmacy, Caremark Rx, L.L.C., Caremark L.L.C. and CaremarkPCS Health LLC.

g. All of the executives of CaremarkPCS Health, L.L.C., Caremark, L.L.C., Caremark Rx, L.L.C., and CVS Pharmacy ultimately report to the executives at CVS Health, including the President and CEO of CVS Health.

142. CVS Health, as a corporate family, does not operate as separate entities. The public filings, documents, and statements of CVS Health presents its subsidiaries, including CVS Pharmacy, CaremarkPCS Health, L.L.C., Caremark, L.L.C., and Caremark Rx, L.L.C. 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."[19]

[19] CVS Caremark/CVS Health, Annual Reports (Form 10-K) (Dec. 31, 2009-2019).

143. 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 discussed in this Complaint. The CVS Health enterprise and each of these entities, both individually and collectively, engaged in the at-issue conduct that gave rise to the Insulin Pricing Scheme.

144. Collectively, Defendants CVS Health, CVS Pharmacy, Caremark Rx, L.L.C., Caremark, L.L.C., and CaremarkPCS Health, L.L.C, including all predecessor and successor entities, are referred to as "CVS Caremark."

145. CVS Caremark is named as a Defendant in its capacities as a PBM and retail and mail order pharmacy.

146. In its capacity as a PBM, CVS Caremark coordinates with Novo Nordisk and Sanofi regarding the artificially-inflated list prices for the at-issue diabetes medications, as well as for the placement of these firms' diabetes medications on CVS Caremark's formularies.

147. CVS Caremark has the largest PBM market share based on total prescription claims managed, representing approximately 40% of the national market. CVS Caremark's pharmacy services segment generated $141.5 billion in total revenues last year.

148. At all times relevant hereto, CVS Caremark offered pharmacy benefit services to Virginia payors, and derived substantial revenue therefrom, and, in doing so, made the at-issue misrepresentations (discussed below) and utilized the

artificially-inflated prices generated by the Insulin Pricing Scheme to profit off Virginia diabetics.

149. At all times relevant hereto, CVS Caremark constructed standard formularies that are used nationwide, including by CVS Caremark's payor clients in Virginia and that are relied on by consumers in Virginia with diabetes as promoting diabetic health and lowering the price of the at-issue drugs.

150. During the relevant time period, these standard formularies included drugs produced by the Manufacturer Defendants, including the at-issue diabetes medications.

151. At all times relevant hereto, and contrary to all its express representations, CVS Caremark has knowingly insisted that its payor clients, including in Virginia, use the artificially-inflated list prices produced by the Insulin Pricing Scheme as the basis for payment for the price paid for the at-issue drugs.

152. At all times relevant hereto, CVS Caremark has concealed its critical role in the generation of those artificially-inflated list prices.

153. In its capacity as a mail order and retail pharmacy, CVS Caremark dispensed the at-issue drugs to Virginia diabetics and received payments from Virginia diabetics and payors based on the artificially-inflated prices produced by the Insulin Pricing Scheme and, as a result, harmed Virginia diabetics.

154. In its capacity as a retail pharmacy, CVS Caremark further and knowingly profited from the artificially-inflated list prices produced by the Insulin Pricing Scheme by pocketing the spread between acquisition cost for the drugs at issue

(an amount well below the list price generated by the Insulin Pricing Scheme), and the amounts they received from payors (which amounts were based on the artificially-inflated list prices and, in many cases, were set by CVS Caremark in its capacity as a PBM).

155. CVS Caremark purchases drugs produced by the Manufacturer Defendants, including the at-issue diabetes medications, for dispensing through its mail order and retail pharmacies.

156. At all times relevant hereto, CVS Caremark had express agreements with Defendants Novo Nordisk and Sanofi related to the Manufacturer Payments paid to CVS Caremark and placement on CVS Caremark's standard formularies; as well as agreements related to the Manufacturers' at-issue drugs sold through CVS Caremark's mail order and retail pharmacies, including those located in Virginia.

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

158. UnitedHealth Group, Inc. may be served through its registered agent: United Agent Group Inc.,1521 Conrod Pike, Suite 201, Wilmington, DE 19803.

159. UnitedHealth Group, Inc. is a diversified managed healthcare company. UnitedHealth Group, Inc. offers a spectrum of goods and services including pharmacy benefits through its wholly-owned subsidiaries.

160. In 2015, UnitedHealth Group listed revenue in excess of $257 billion, and the company is currently ranked fifth on the Fortune 500 list. More than one-third of the overall revenues of UnitedHealth Group come from OptumRx and OptumInsight.

161. UnitedHealth Group, through its executives and employees, is directly involved 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. For example, executives of UnitedHealth Group structure, analyze, and direct the company's overarching, enterprise-wide policies, including PBM and mail-order services, as a means of maximizing profits across the corporate family.

162. UnitedHealth Group's Sustainability Report states that it "works directly with pharmaceutical manufacturers to secure discounts that lower the overall cost of medications and create tailored formularies – or drug lists – to ensure people get the right medications. [*UnitedHealth Group*] then negotiate[s] with pharmacies to lower costs at the point of sale . . . [*UnitedHealth Group*] also operate[s] [mail order pharmacies] . . . [*UnitedHealth Group*] work[s] directly with drug wholesalers and distributors to ensure consistency of the brand and generic drug supply, and a reliance on that drug supply."[20]

163. On a regular basis throughout the relevant time period, executive teams from each Manufacturer Defendant—including at times their CEOs—met with

[20] *Sustainability Report: Fulfilling Our Mission*, UNITED HEALTH GROUP (Apr. 2020), https://www.unitedhealthgroup.com/content/dam/UHG/PDF/sustainability/final/4_2020_SustainabilityReport_RBP.pdf.

executives from UnitedHealth Group to discuss their coordinated efforts in furtherance of the Insulin Pricing Scheme. Examples include:

a. In 2014, the CEO and Senior Vice President of UHG met with executives at Novo Nordisk and engaged in discussions, including involving topics that related to the Insulin Pricing Scheme.

b. In at least 2014 and 2018, executives at UnitedHealth Group, including CEOs, met with executives at Sanofi, including CEO of Sanofi to engage in discussions, including involving topics that related to the Insulin Pricing Scheme. Sanofi's stated objective for these meetings was to "[l]everage the entire Sanofi portfolio of assets to set the stage for future business development with UHG, along with establishing a stronger executive level strategic relationship with UHG."

164. In 2011, UHG invested significantly in building out its capabilities. This included UHG forming an enterprise wide UHG Pharmacy Steering Committee to oversee all UHG-related formularies, including OptumRx, with the goal of aligning their formularies/prescription drug lists across all their segments (Medicare, commercial and managed care) and moving to one pharmacy & therapeutics ("P&T")[21] committee in 2012. This effort also included tasking OptumRx with negotiating rebates and manufacturer contracts for all UHG enterprise-wide formularies.

[21] PBM's P&T Committees evaluate the clinical effectiveness of drugs and determines if they must be included, must be excluded, and/or are optional for PBMs' formularies.

165. UnitedHealth Group's conduct had a direct effect in Virginia and harmed diabetics and payors in Virginia.

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

167. OptumInsight, Inc. has a certificate of authority to and transacts business in Virginia and may be served through its registered agent: United Agent Group Inc., 425 W. Washington Street, Suite 4, Suffolk, VA 23434.

168. During the relevant time period, due to name changes and mergers, a number of different entities make up what is now known as OptumInsight, including Ingenix, Innovus, i3, QualityMetric, Htanalytics, ChinaGate, CanReg, and the Lewin Group. For the purposes of this Complaint, "OptumInsight" refers to each of these entities.

169. OptumInsight is an integral part of the Insulin Pricing Scheme, and during the relevant time period OptumInsight coordinated directly with the Manufacturer Defendants.

170. OptumInsight analyzed data and other information from the PBM and Manufacturer Defendants to advise Defendants with regard to the profitability of the Insulin Pricing Scheme to the benefit of all Defendants.

171. Each Manufacturer Defendant had dedicated executives assigned to OptumInsight for the purpose of collaborating with key executives and coordinating with OptumInsight for data acquisition and utilization.

172. The Manufacturers utilized their relationships with OptumInsight to deepen their ties to the overall UnitedHealth Group corporate family and to secure formulary wins for their diabetes medications.

173. During the relevant time period, OptumInsight partnered with OptumRx to offer the at-issue pharmacy benefit and data and cost analysis services that gave rise to the Insulin Pricing Scheme to Virginia diabetics.

174. **Defendant OptumRx, Inc.** is a California corporation with its principal place of business at 2300 Main St., Irvine, California, 92614.

175. OptumRx, Inc. has a certificate of authority to and transacts business in Virginia and may be served through its registered agent: United Agent Group Inc., 425 W. Washington Street, Suite 4, Suffolk, VA 23434.

176. During the relevant time period, OptumRx, Inc. provided the PBM and mail-order pharmacy services in Virginia that gave rise to the Insulin Pricing Scheme, which harmed diabetics in Virginia.

177. As a result of numerous interlocking directorships and shared executives, UnitedHealth Group is directly involved in the conduct and control of OptumInsight and OptumRx's operations, management, and business decisions related to the at-issue formulary construction, negotiations, and mail-order pharmacy services to the ultimate detriment of Virginia diabetics.

178. For example, these parent and subsidiaries have common officers and directors, including:

a. Sir Andrew Witty is president of UnitedHealth Group and CEO of Optum, Inc.;

b. Dan Schumacher is president of Optum, Inc, the Chief Strategy and Growth Officer at UnitedHealth Group, Inc. and oversees OptumInsight;

c. Terry Clark is a senior vice president and chief marketing officer at UnitedHealth Group and also oversees the branding, marketing, and advertising for UnitedHealth Group and Optum, Inc.;

d. Tom Roos serves as chief accounting officer for UnitedHealth Group and Optum, Inc.;

e. Heather Lang is Deputy General Counsel, Subsidiary Governance at UnitedHealth Group, Inc. and also Assistant Secretary at OptumRx, Inc.;

f. Peter Gill is Vice President at UnitedHealth Group, Inc. and also Treasurer at OptumRx, Inc.;

g. John Santelli leads Optum Technology, the leading technology division of Optum, Inc. serving the broad customer base of Optum and UnitedHealthcare and also serves as UnitedHealth Group's chief information officer;

h. Eric Murphy is the Chief Growth and Commercial Officer for Optum, Inc. and has also led OptumInsight, Inc.

i. Timothy Wicks, CFO and Executive Vice President of Industry and Network relations for OptumRx, Inc. also held executive management positions with UnitedHealth Group including operations product management and business development roles at UnitedHealthcare, OptumInsight and most recently, Optum Shared Services.

179. UnitedHealth Group directly or indirectly owns all the stock of OptumRx, Inc. and OptumInsight, Inc.

180. The UnitedHealth Group corporate family does not operate as separate entities. The public filings, documents, and statements of UnitedHealth Group presents its subsidiaries, including OptumRx, Inc. and OptumInsight as divisions or departments of a single company that is a diversified family of businesses that leverages core competencies to "help[] people live healthier lives and helping make the health system work better for everyone."[22]

181. 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. Indeed, UHG and OptumRx represent directly to their clients and potential clients in Virginia that the "Optum family of companies—OptumRx, OptumHealth and OptumInsight—each wholly

[22] UNITED HEALTH GROUP, *Mission and Values: Helping people live healthier lives and helping make the health system work better for everyone*, https://www.unitedhealthgroup.com/uhg/mission-values.html (last visited Dec. 18, 2025).

owned subsidiaries of UnitedHealth Group" work as a cohesive unit to offer the at-issue services related to the Insulin Pricing Scheme in Virginia.

182. The UnitedHealth Group enterprise and each of these entities, both individually and collectively, engaged in the at-issue conduct that gave rise to the Insulin Pricing Scheme.

183. All the executives of OptumRx, Inc. and OptumInsight ultimately report to the executives, including the CEO, of UnitedHealth Group.

184. As stated above, UnitedHealth Group's executives and officers are directly involved in the policies and business decisions of OptumRx, Inc. and OptumInsight that gave rise to the Commonwealth's claims in this Complaint.

185. Collectively, Defendants UnitedHealth Group, OptumRx, Inc., and OptumInsight, Inc., including all predecessor and successor entities, are referred to as "OptumRx."

186. OptumRx is named as a Defendant in its capacities as a PBM and mail-order pharmacy.

187. In its capacity as a PBM, OptumRx coordinates with Novo Nordisk and Sanofi regarding the artificially-inflated list prices for the at-issue diabetes medications, as well as, for the placement of these firms' diabetes medications on OptumRx's drug formularies.

188. On a regular basis throughout the relevant time period, executive teams from each Manufacturer Defendant—including at times their CEOs—met with executives from OptumRx to discuss their coordinated efforts in furtherance of the

Insulin Pricing Scheme. For example, in at least April 2015, the Executive Vice President at UnitedHealth Group, the Chief Commercial Officer at Optum Analytics, the Vice President of OptumRx, the Vice President of OptumInsight, among other executives met with Vice President of Market Access and the Executive Vice President of Strategic Accounts, among other executives from Novo Nordisk at UnitedHealth Group's corporate headquarters to discuss their strategic overview and prioritized opportunities in diabetes.

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

190. In 2019, OptumRx managed more than $96 billion in pharmaceutical spending, with a revenue of $74 billion.

191. Prior to 2011, OptumRx was known as Prescription Solutions. In addition, OptumRx rose to power through numerous mergers with other PBMs. For example, in 2012, a large PBM, SXC Health Solutions, bought one of its largest rivals, Catalyst Health Solutions Inc. in a roughly $4.14 billion deal. Shortly thereafter, SXC Health Solutions Corp. renamed the company Catamaran Corp. Following this, UnitedHealth Group bought Catamaran Corp in a deal worth $12.8 billion and combined Catamaran with OptumRx.

192. Prior to merging with OptumRx (or being renamed), Prescription Health Solutions, Catalyst Health Solutions, Inc., and Catamaran Corp. engaged in the at-issue PBM and mail order activities in Virginia.

193. At all times relevant hereto, OptumRx derived substantial revenue providing pharmacy benefits in Virginia.

194. At all times relevant hereto, and contrary to all their express representations, OptumRx has knowingly insisted that its payor clients, including its payor clients in Virginia, use the artificially-inflated list prices produced by the Insulin Pricing Scheme as the basis for reimbursement of the at-issue drugs.

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

196. At all times relevant hereto, OptumRx offered pharmacy benefit management services nationwide and constructed standard formularies that are used throughout Virginia by payors and diabetics, and that are relied on by consumers in Virginia with diabetes as promoting diabetic health and lowering the price of the at-issue drugs. During the relevant time period, these standard formularies included the at-issue diabetes medications.

197. In its capacity as a mail-order pharmacy, OptumRx dispensed the at-issue drugs to Virginia diabetics and received payments from Virginia diabetics and payors based on the artificially-inflated prices produced by the Insulin Pricing Scheme and, as a result, harmed Virginia diabetics.

198. At all times relevant hereto, OptumRx purchased drugs produced by the Manufacturer Defendants, including the at-issue diabetes medications, and dispensed the at-issue medications to diabetics in Virginia through its mail-order pharmacies.

199. At all times relevant hereto, OptumRx had express agreements with Defendants Novo Nordisk and Sanofi 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's mail-order pharmacies.

200. Collectively, CVS Caremark, OptumRx, and Express Scripts are referred to as "PBM Defendants" or "PBMs."

C. Manufacturer Defendants

201. **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.

202. Sanofi may be served through its registered agent: Corporation Service Company, 251 Little Falls Drive, Wilmington, New Castle, DE 19808.

203. Sanofi holds active licenses with the Virginia Board of Pharmacy.

204. These licenses allow Sanofi to manufacture, distribute, and sell its at-issue drugs in Virginia.

205. Sanofi promotes and distributes pharmaceutical drugs in Virginia, including several at-issue diabetes medications: Lantus, Toujeo, Soliqua, Adlyxin, and Apidra.

206. Sanofi's global revenues in 2024 were $1.92 billion from Lantus, $1.45 billion from Toujeo, and $268 million from Soliqua. Apidra global revenues in 2020 were $391 million.

207. Sanofi's global revenues in 2023 were $1.67 billion from Lantus, $1.32 billion from Toujeo, and $256 million from Soliqua. Apidra global revenues in 2019 were $405 million.

208. Sanofi transacts business in Virginia and targets Virginia for its goods, including the at-issue diabetes medications.

209. Sanofi employs sales representatives throughout Virginia to promote and sell Lantus, Toujeo, Soliqua, and Apidra.

210. Sanofi also directs advertising and informational materials to Virginia physicians, payors, pharmacies, and diabetics for the specific purpose of selling more of the at-issue drugs in Virginia and profiting from the Insulin Pricing Scheme.

211. At all times relevant hereto, in furtherance of the Insulin Pricing Scheme, Sanofi caused its artificially-inflated list prices for the at-issue diabetes medications to be published throughout Virginia with the express knowledge that payment and reimbursement by Virginia diabetics would be based on these prices.

212. During the relevant time period, diabetics in Virginia spent millions of dollars per year out of pocket on Sanofi's at-issue drugs also based on Sanofi's artificially-inflated list prices.

213. Virginia diabetics paid for all of the Sanofi diabetes medications related to the at-issue transactions in Virginia based on the specific inflated prices Sanofi caused to be published in Virginia in furtherance of the Insulin Pricing Scheme.

214. **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.

215. Novo Nordisk has a certificate of authority to and transacts business in Virginia and may be served through its registered agent: CT Corporation System, 4701 Cox Rd Suite 285, Glen Allen, VA, 23060.

216. Novo Nordisk promotes and distributes pharmaceutical drugs in Virginia, including at-issue diabetic medications: Novolin R, Novolin N, Novolog, Levemir, Tresiba, Victoza, Rybelsus, Xultophy, and Ozempic.

217. Novo Nordisk's global revenues in 2024 were $3.6 billion from Novolog, $747 million from Levemir, $1.58 billion from Tresiba, $877 million from Victoza, $720 million from Xultophy, $3.73 billion from Rybelsus, and $19.25 billion from Ozempic.

218. Novo Nordisk's global revenues in 2023 were $3.14 billion from Novolog, $629 million from Levemir, $1.24 billion from Tresiba, $1.39 billion from Victoza, $515 million from Xultophy, $3 billion from Rybelsus, and $15.31 billion from Ozempic.

219. Novo Nordisk transacts business in Virginia, targeting Virginia for its goods, including the at-issue diabetes medications.

220. Novo Nordisk employs sales representatives throughout Virginia to promote and sell Novolin R, Novolin N, Novolog, Levemir, Tresiba, Xultophy, Rybelsus, Victoza, and Ozempic.

221. Novo Nordisk also directs advertising and informational materials to Virginia physicians, payors, pharmacies, and diabetics for the specific purpose of

selling more of the at-issue drugs in Virginia and profiting from the Insulin Pricing Scheme.

222. At all times relevant hereto, in furtherance of the Insulin Pricing Scheme, Novo Nordisk caused its artificially-inflated list prices for the at-issue diabetes medications to be published throughout Virginia with the express knowledge that Virginia diabetics paid for the at-issue drugs based on these prices.

223. During the relevant time period, diabetics in Virginia spent millions of dollars per year out of pocket on Novo Nordisk's at-issue drugs also based on Novo Nordisk's artificially-inflated list prices.

224. Virginia diabetics paid for all of the Novo Nordisk diabetes medications related to the at-issue transactions in Virginia based on the specific inflated prices Sanofi caused to be published in Virginia in furtherance of the Insulin Pricing Scheme.

225. Collectively, Defendants Novo Nordisk and Sanofi are referred to as "Manufacturer Defendants" or "Manufacturers."

226. Collectively, the "PBM Defendants" and the "Manufacturer Defendants" are referred to as "Defendants."

III. JURISDICTION AND VENUE

227. This action is brought by the Commonwealth of Virginia, ex rel. Jason S. Miyares, Virginia Attorney General, pursuant to the provisions of the Virginia Consumer Protection Act. This Court has personal jurisdiction over each Defendant because each Defendant: (a) transacts business and/or is admitted to do business within Virginia, (b) maintains substantial contacts in Virginia, and (c) committed the violations of the VCPA at issue in this lawsuit in whole or part within Virginia. The

Insulin Pricing Scheme has been directed at, and has had the foreseeable and intended effect of, causing injury to persons in Virginia.

228. All of the at-issue transactions occurred in Virginia and/or involved Virginia residents.

229. Venue for this action is preferred in the City of Richmond, Virginia pursuant to Virginia Code § 8.01-261(15)(c) because some of the acts to be enjoined are, or were, being done in the City of Richmond. Venue is permissible in this Court pursuant to Virginia Code § 8.01-262(3) and (4) because Defendants regularly conduct substantial business activity within the City of Richmond, and the counts alleged here arose, in part, in the City of Richmond.

230. In accordance with Virginia Code § 59.1-203(B), before commencing this action, the Commonwealth gave written notice that these proceedings were contemplated and a reasonable opportunity for Defendants to appear before the Office of the Attorney General to show that no violations of the Virginia Consumer Protection Act had occurred, or, in the alternative, to execute an appropriate Assurance of Voluntary Compliance that is acceptable to the Commonwealth. None of the Defendants showed that no violations had occurred, and none of the Defendants executed an appropriate Assurance of Voluntary Compliance.

IV. FACTUAL ALLEGATIONS

A. Diabetes and Insulin Therapy

1. Diabetes: A growing epidemic

231. Diabetes is a disease that occurs when a person's blood glucose, also called blood sugar, is too high. In a non-diabetic person, the pancreas secretes the

hormone insulin, which controls the rate at which food is converted to glucose, or sugar, in the blood. When there is not enough insulin or cells stop responding to insulin, too much blood sugar stays in the bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease.

232. There are two basic types of diabetes. Roughly 90-95% of diabetics developed the disease because they do not produce enough insulin or have become resistant to the insulin their bodies do produce. Known as Type 2, this form of diabetes is often developed later in life. While Type 2 patients can initially be treated with tablets, in the long term most patients have to switch to insulin injections.

233. Type 1 diabetes occurs when a patient's body completely ceases insulin production. In contrast to Type 2 patients, people with Type 1 diabetes do not produce any insulin and, without regular injections of insulin, they will die.

234. Insulin and other diabetic treatments are a necessary part of life for those who have diabetes, and interruptions to a diabetic's insulin regimen can have severe consequences. Missed or inadequate insulin therapy can trigger hyperglycemia and then diabetic ketoacidosis. Left untreated, diabetic ketoacidosis can lead to loss of consciousness and death within days.

235. The number of Americans with diabetes has grown significantly in the last half century. In 1958, only 1.6 million people in the United States had diabetes. By the turn of the century, that number had grown to over ten million. Fourteen years later, the count tripled again. Now over thirty million people—9.4% of the country—live with the disease.

236. Likewise, the prevalence of diabetes in Virginia has been steadily increasing as well, hundreds of thousands of Virginia adults now live with diabetes and over 2 million have prediabetes.[23]

237. The burden of diabetes is not equally distributed in Virginia. Diabetes is significantly more prevalent in impoverished regions; nearly 1 in 5 Virginia residents who earn less than $20,000 a year have diabetes.[24]

2. Insulin: A century old drug

238. Despite its potentially deadly impact, diabetes is a highly treatable illness. For patients who are able to follow a prescribed treatment plan consistently, the health complications associated with the disease are avoidable.

239. Unlike many high-burden diseases, treatment for diabetes has been available for almost a century.

240. In 1922, Frederick Banting and Charles Best, while working at the University of Toronto, pioneered a technique for removing insulin from an animal pancreas that could then be used to treat diabetes.

241. After discovery, Banting and Best obtained a patent and then sold it to the University of Toronto for $1 (equivalent of $14 today), explaining "[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."

[23] VIRGINIA HEALTH DEP'T, *Diabetes and Prediabetes Data*, https://www.vdh.virginia.gov/diabetes/data/ (last visited Sept. 23, 2025).

[24] *Id.*

242. After purchasing the patent, the University of Toronto contracted with Defendant Novo Nordisk—as well as one additional insulin manufacturer—to scale their production. Under this arrangement, Novo Nordisk and the other insulin manufacturer were allowed to apply for patents on variations to the manufacturing process.

243. Although early iterations of insulin were immediately perceived as lifesaving, there have been numerous incremental improvements since its discovery.

244. The earliest insulin was derived from animals and, until the 1980s, was the only treatment for diabetes.

245. While effective, animal-derived insulin created the risk of allergic reaction. This risk was lessened in 1982 when synthetic insulin, known as human insulin, was developed.

246. The development of human insulin benefited heavily from government and non-profit funding through the National Institute of Health and the American Cancer Society.

247. Over a decade later, the first analog insulin was released in 1996.

248. Analog insulin is laboratory grown and genetically altered insulin. Analogs are slight variations on human insulin that make the injected treatment act more like the insulin naturally produced and regulated by the body.

249. Rapid-acting analogs include Defendant Novo Nordisk's Novolog and Defendant Sanofi's Apidra, with similar profiles. Diabetics use these rapid-acting

insulins in combination with longer-acting insulins, such as Sanofi's Lantus and Novo Nordisk's Levemir.

250. In 2015, Sanofi introduced Toujeo, another long-acting insulin also similar to Lantus. Toujeo is highly concentrated, making injection volume smaller than Lantus.

251. Even though insulin was first extracted nearly one hundred years ago, only Defendants Novo Nordisk and Sanofi—along with one other insulin manufacturer—manufacture insulin in the United States.

252. Many of the at-issue diabetes medications are now off patent. However, due in large part to their ability to stifle all competition, Manufacturer Defendants—along with one other insulin manufacturer—make 99% of the insulins in the market today.

3. Current diabetes medication landscape

253. While insulin today is generally safer and more convenient to use than when originally developed in 1922, there remain questions whether the overall efficacy of insulin has significantly improved over the last twenty years.

254. For example, while long-acting analogs may have certain advantages over human insulins (such as affording more flexibility around mealtime planning), it has yet to be shown that analogs lead to better long-term outcomes.

255. A 2018 study published in the Journal of American Medical Association suggests that older human insulins may work just as well as newer analog insulins for patients with Type 2 diabetes.[25]

256. When discussing the latest iterations of insulins, Harvard Medical School professor David Nathan recently stated:

> I don't think it takes a cynic such as myself to see most of these [insulins] are being developed to preserve patent protection. The truth is they are marginally different, and the clinical benefits of them over the older drugs have been zero.[26]

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

258. Dr. Kasia Lipska, a Yale researcher and author of a 2018 study in the Journal of the American Medical Association on the cost of insulin, explained:

> 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 . . . there's nothing that's changed about [these insulins]. It's the same insulin that's just gone up in price and now costs ten times more.[27]

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[25] Luo J, Khan NF, Manetti T, et al., *Implementation of a Health Plan Program for Switching From Analogue to Human Insulin and Glycemic Control Among Medicare Beneficiaries With Type 2 Diabetes*, JAMA (Jan. 29, 2019), https://jamanetwork.com/journals/jama/fullarticle/2722772.

[26] Carolyn Y. Johnson, *Why treating diabetes keeps getting more expensive,* WASH. POST (Oct. 31, 2016), https://www.washingtonpost.com/news/wonk/wp/2016/10/31/why-insulin-prices-have-kept-rising-for-95-years/.

[27] Kendall Teare, *One in four patients say they've skimped on insulin because of high cost*, YALENEWS (Dec. 3, 2018), https://news.yale.edu/2018/12/03/one-four-patients-say-theyve-skimped-insulin-because-high-cost.

259. Nor have the production or research and development costs increased. In fact, in the last 10 years, the production costs of insulin have decreased as manufacturers simplified and optimized processes.

260. A September 2018 study published in BMJ Global Health calculated that, based on production costs, a reasonable price for a year's supply of human insulin is $48 to $71 per person and between $78 and $133 for analog insulins—which includes delivering a profit to manufacturers.[28]

261. Likewise, in March 2024, a similar study conducted by a team of researchers from Yale University, King's College Hospital in London, and Boston-based Harvard Medical School published findings that GLP-1s and other Type 2 diabetes medications, including those at-issue in this Complaint, could be manufactured for between 89 cents and $4.73 per month.[29]

262. These "cost-based" estimates both for GLP-1s and insulin are based on researchers' evaluation of manufacturing costs plus a profit margin with an allowance for tax.

263. These figures stand in stark contrast to the $5,705 that a diabetic spent, on average, on insulin in 2016.

264. Further, while research and development costs often make up a large percentage of the price of a drug, in the case of insulin the initial basic research—

[28] Gotham, D. et al., *Production costs and potential prices for biosimilars of human insulin and insulin analogues*, BMJ GLOB. HEALTH (2018), https://gh.bmj.com/content/bmjgh/3/5/e000850.full.pdf.

[29] Hegland, T. et al., *GLP-1 Medication Use for Type 2 Diabetes Has Soared*, JAMA (Sept. 24, 2024), https://pubmed.ncbi.nlm.nih.gov/39212980/.

original drug discovery and patient trials—was performed one hundred (100) years ago.

265. Even the more recent costs, such as developing the recombinant DNA fermentation process and the creation of insulin analogs, the Manufacturers incurred decades ago.

266. Today, Manufacturer Defendants only spend a fraction of the billions of dollars in revenue they generate from the at-issue drugs on research and development.

267. Despite this decrease in production costs and no new research and development, the reported price of insulins has risen dramatically over the last fifteen years.

4. Insulin adjuncts: Type 2 medications

268. Over the past two decades, Manufacturer Defendants have also released a number of non-insulin medications that help control the level of insulin in the bloodstream of Type 2 diabetics.

269. In 2010, Novo Nordisk released Victoza as an adjunct to insulin to improve glycemic control. In 2016, Sanofi released a similar drug, Soliqua, and in 2017, Novo Nordisk released Ozempic.

270. Victoza and Ozempic are medications known as glucagon-like peptide-1 receptor agonists ("GLP-1") and are similar to the GLP-1 hormone that is already produced in the body. Soliqua is a combination long-acting insulin and GLP-1 drug. Each of these drugs can be used in conjunction with insulins to control diabetes.

271. Today, Manufacturer Defendants have a dominant position in the market for all diabetes medications. The following is a list of diabetes medications at issue in this lawsuit:

Table 1:
Diabetes medications at issue in this case

Insulin Type	*Action*	*Name*	*Company*	*FDA Approval*
Human	**Rapid-Acting**	Novolin R	Novo Nordisk	1991
	Intermediate	Novolin N	Novo Nordisk	1991
		Novolin 70/30	Novo Nordisk	1991
Analog	**Rapid-Acting**	Novolog	Novo Nordisk	2000
		Apidra	Sanofi	2004
	Long-Acting	Lantus	Sanofi	2000
		Levemir	Novo Nordisk	2005
		Toujeo	Sanofi	2015
		Tresiba	Novo Nordisk	2015
Type 2 Medications		Victoza	Novo Nordisk	2010
		Ozempic	Novo Nordisk	2017
		Xultophy	Novo Nordisk	2016
		Rybelsus	Novo Nordisk	2019
		Soliqua	Sanofi	2016
		Adlyxin	Sanofi	2016

B. The Dramatic Rise in the Price of Diabetes Medications

1. Diabetes medication price increases

272. In 2003, PBMs began their rise to power.

273. That same year, the price of insulin began its dramatic rise to its current high level.

274. Since 2003, the list price of certain insulins has increased in some cases by more than 1000%; a substantial increase especially when compared to a general inflation rate of 8.3% and a medical inflation rate of 46% in this time period.

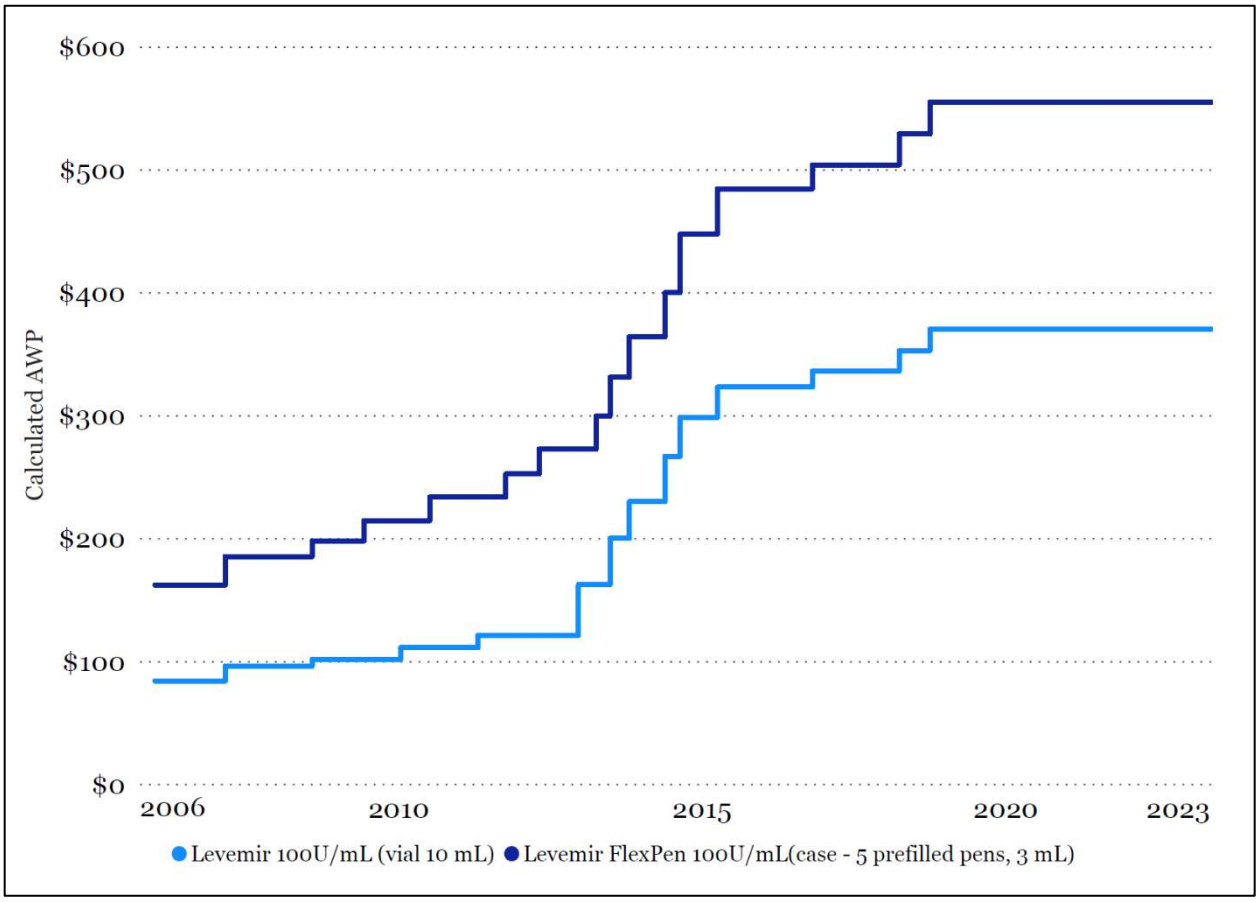
275. By 2016, the average price per month for the four most popular types of insulin rose to $450 — and costs continue to rise.

276. One in four diabetics are now skimping on or skipping lifesaving doses. This behavior is dangerous to a diabetic's health and can lead to a variety of complications and even death.

277. From 2006 to 2023, Novo Nordisk artificially inflated the list price of Levemir from $162 to $555 for pens and from under $100 to $370 per vial (*See* Figure 1:

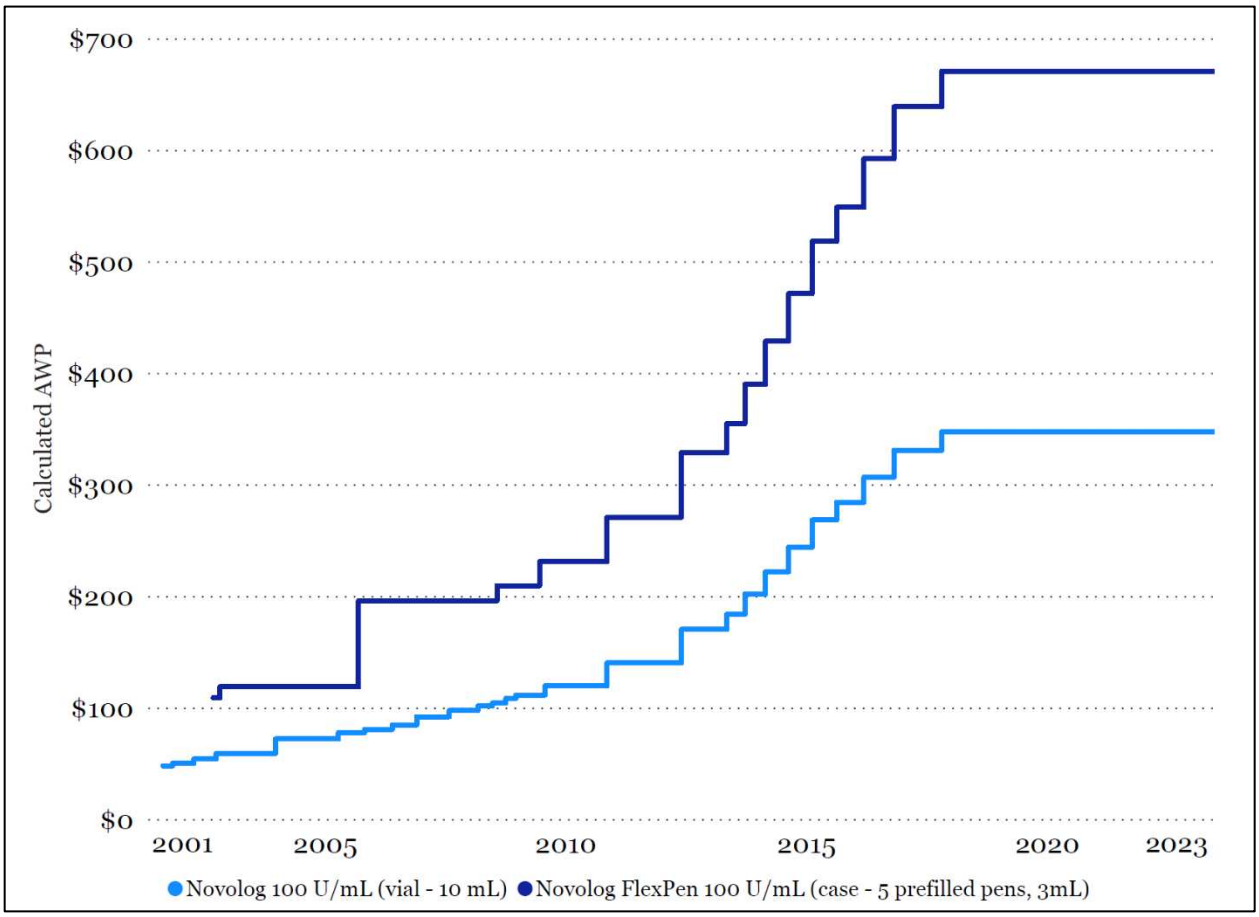
Rising list prices of Levemir from 2006-2021).

Figure 1:
Rising list prices of Levemir
from 2006-2021



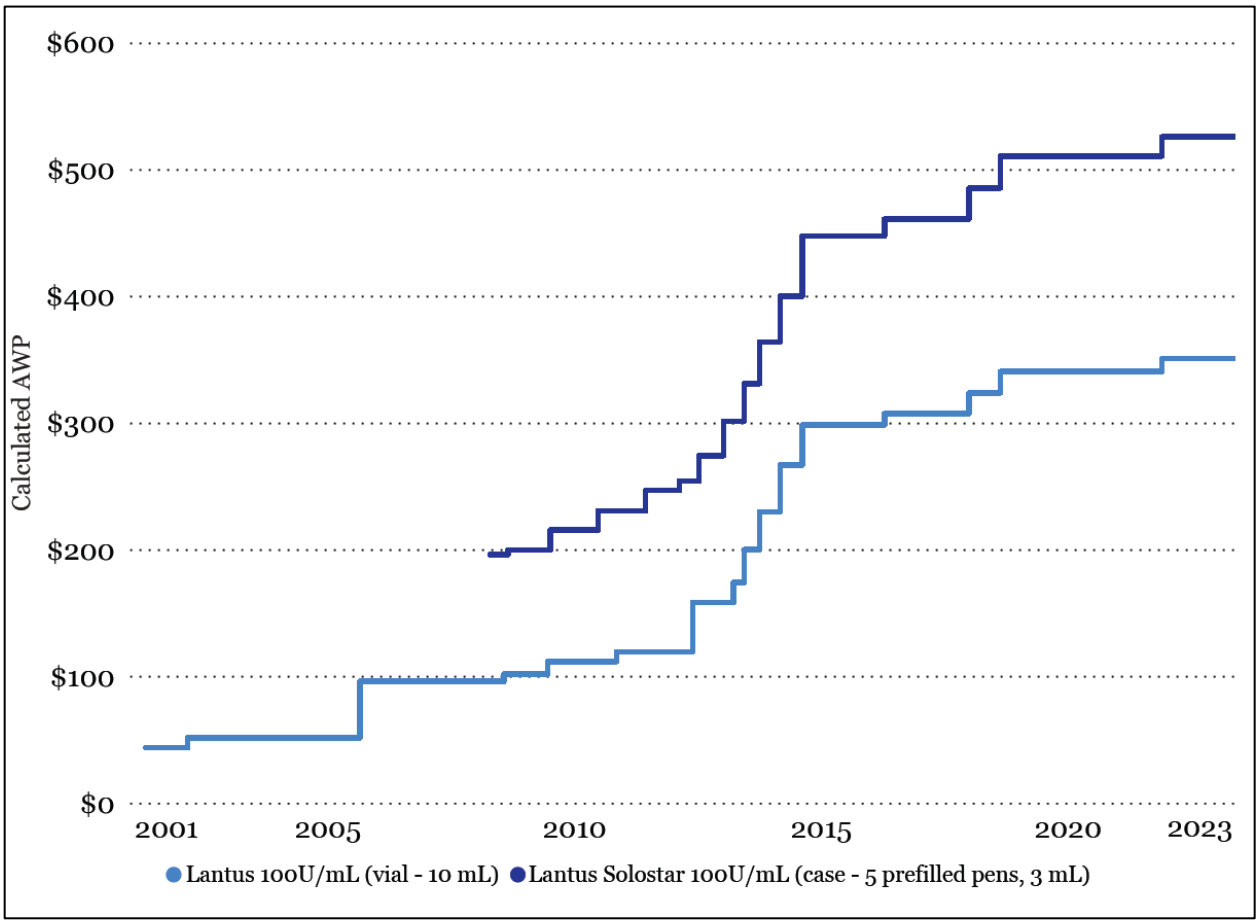
278. From 2002 to 2023, Novo Nordisk has artificially inflated the list price of Novolog from $108 to $671 for a package of pens and from less than $50 to $347 for a vial (*See* Figure 2).

Figure 2:
Rising list prices of Novolog vials and pens from 2002-2021



279. Defendant Sanofi has kept pace as well, artificially inflating the list price for Lantus, the top-selling analog insulin, from less than $200 in 2006, to over $500 in 2023 for a package of pens and from less than $50 to $340 for a vial (*See* Figure 3).

Figure 3:
Rising list prices of Lantus vials and pens
from 2001-2021



280. Manufacturer Defendants' non-insulin diabetes medications have experienced similar recent price increases.

281. Driven by these price increases, payors' and diabetics' spending on diabetes medications has substantially increased with totals in the tens of billions of dollars.

2. Manufacturers increased prices in lockstep

282. The timing of the list price increases reveal that each Manufacturer Defendant has not only increased prices for the at-issue diabetes treatments, but they have also done so in perfect lockstep.

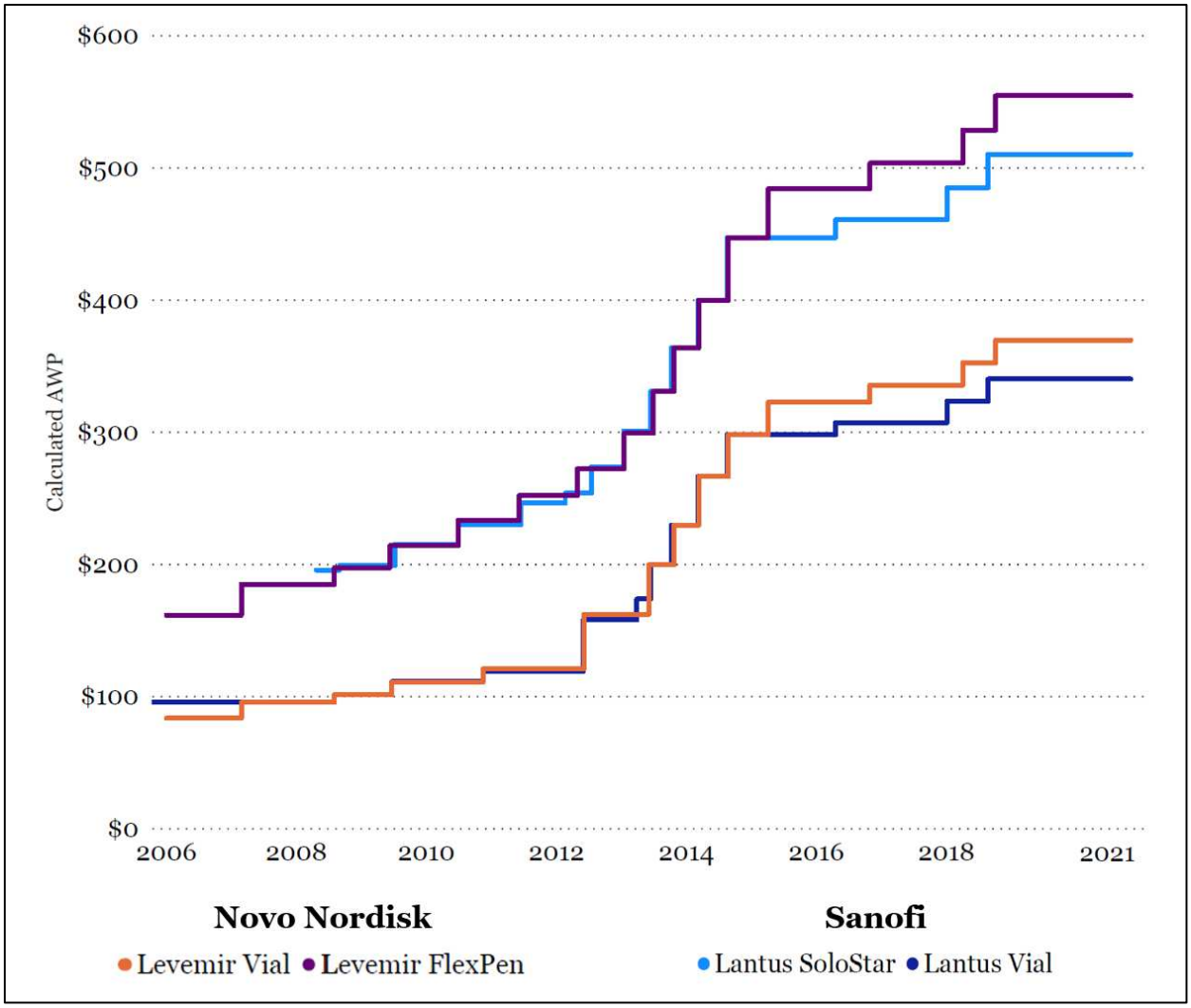
283. In thirteen instances since 2009, competitors Sanofi and Novo Nordisk raised the list prices of their insulins, Lantus and Levemir, in tandem, taking the same price increase down to the decimal point within a few days of each other.

284. This practice of increasing drug prices in lockstep with competitors is known as "shadow pricing" and, as healthcare expert Richard Evans from SSR Health recently stated, "is pretty much a clear signal that your competitor does not intend to price-compete with you."[30]

285. In 2016, Novo Nordisk and Sanofi's lockstep increases for the at-issue drugs were responsible for the highest drug price increases in the entire pharmaceutical industry. Figure 4 demonstrates these price increases with respect to Lantus and Levemir.

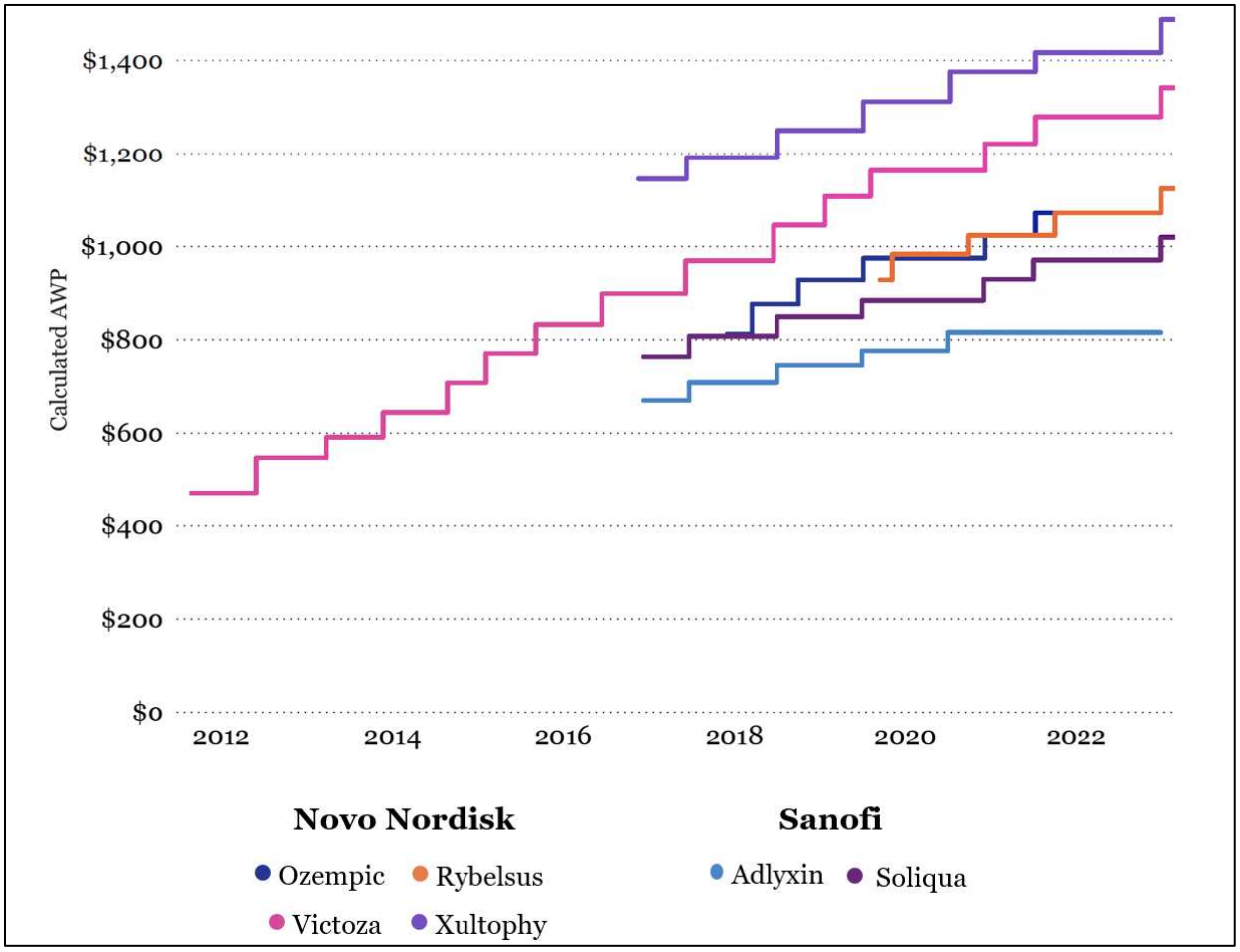
[30] Langreth, Robert, *Hot Drugs Show Sharp Price Hikes in Shadow Market*, BLOOMBERG (MAY 6, 2015), https://www.bloomberg.com/news/articles/2015-05-06/diabetes-drugs-compete-with-prices-that-rise-in-lockstep?embedded-che ckout=true.

Figure 4:
Rising list prices of long-acting insulins
from 2006-2021



286. Figure 5 demonstrates Defendants' price increases for their Type 2 drugs.

Figure 5:
Rising list prices of Type 2 drugs
from 2012-2022



287. Because of Manufacturer Defendants' collusive price increases, nearly a century after the discovery of insulin, diabetes medications have become unaffordable for many diabetics.

C. Pharmaceutical Payment and Supply Chain

288. The prescription drug industry consists of a deliberately opaque network of entities engaged in multiple distribution and payment structures. These entities include drug manufacturers, wholesalers, pharmacies, health plans/third party payors, pharmacy benefit managers, and patients.

289. Generally speaking, branded prescription drugs, such as the at-issue diabetes medications, are distributed in one of two ways: (a) from manufacturer to wholesaler, wholesaler to pharmacy and pharmacy to patient; or (b) from manufacturer to mail order pharmacy to patient.

290. The pharmaceutical industry, however, is unique in that the pricing chain is distinct from the distribution chain.

291. The prices for the drugs distributed in the pharmaceutical chain are different for each participating entity: 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 directly tied to manufacturer's list price.

292. The PBMs ensure there is no transparency in this pricing system and that all of their clients' and patients' payments are tied to the "list prices," typically wholesale acquisition cost ("WAC"), or average wholesale price ("AWP").

293. Manufacturers set the WAC price. Even though the WAC name implies that it is the price that wholesalers pay for drugs, that is not true in practice. After chargebacks and other discounts, wholesalers pay substantially less than the WAC price.

294. Drug manufacturers self-report list prices to publishing compendiums such as First DataBank, Redbook and others who then publish the prices.

295. AWP prices are either set by the manufacturer and then reported to publishing compendiums, or are calculated by the publishing compendium based on the WAC price and then published. AWPs are set at generally 20% greater than WAC.

296. PBMs use AWP prices to set the amount that their payor clients pay for prescription drugs because it is a higher price.

297. Notwithstanding their knowledge that list prices are disconnected from actual transaction costs, the PBM Defendants insist that their clients and patients make payments for the at-issue drugs based on list prices. Even while PBM Defendants have more accurate pricing available, they persist in requiring AWP to be used by payors and patients.

298. As a direct result of Defendants' conduct, their misleading, unlawful, and deceptive list prices persist as the most commonly and continuously used prices in reimbursement and payment calculations and negotiations for all payors.

299. Notably, the Manufacturer Defendants are not required to report or publish only WAC and/or AWP list prices. Nothing prevents them from publishing their net prices, but they choose not to—in furtherance of the Insulin Pricing Scheme.

300. Moreover, the PBM Defendants are not required to use list prices to set the prices paid by their clients and diabetics.

301. Rather, the PBM Defendants continue to perpetuate the use of list prices as the basis of their contracts with their clients and pharmacies because it provides unchecked profitability—through Manufacturer Payments and pharmacy spread pricing (discussed in detail below).

1. Drug Costs for Diabetics

302. Whether insured or not, many Virginia diabetics pay for their diabetic drug costs based on the false list prices generated by the Insulin Pricing Scheme.

303. Uninsured diabetics must pay the full, point-of-sale prices (based on the artificial prices generated by the Insulin Pricing Scheme) every time they fill their prescriptions. In Virginia, 6.4% of the population is uninsured.[31] Approximately 18% of uninsured Virginia residents are diabetic. As a direct result of the Insulin Pricing Scheme, the prices uninsured Virginia residents pay for the at-issue life-sustaining drugs has substantially increased over approximately the last fifteen years.

304. The uninsured are not the only patients saddled with high costs. Insured diabetics also often pay a significant portion of a drug's price out-of-pocket including deductibles; coinsurance requirements; and/or copayment requirements based on the artificially-inflated list prices generated by the Insulin Pricing Scheme.

[31] *Health Insurance Coverage of the Total Population (2023)*, KFF, https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Dec. 18, 2025).

305. Thus, nearly all Virginia diabetics have been harmed by having to pay for diabetes medications out-of-pocket based upon the specific artificially-inflated prices generated by the Insulin Pricing Scheme. In many cases, the Virginia diabetics have been priced out of these life-sustaining drugs.

306. In addition, these indefensible out-of-pocket costs created by the Insulin Pricing Scheme make it more difficult for patients to adhere to their medications, resulting in avoidable complications and higher overall healthcare costs.

307. An American Diabetes Association working group recently noted that "people with high cost-sharing are less adherent to recommended dosing, which results in short- and long-term harm to their health."[32]

308. As executives from the PBM Defendants have explicitly recognized, lack of adherence drives up costs for Virginia diabetics.

309. On May 10, 2023, the Senate Health, Education, Labor, and Pensions (HELP) Committee held a hearing entitled "The Need to Make Insulin Affordable for All Americans" ("2023 Senate Insulin Hearing") (discussed in greater detail below).

310. President of CVS Caremark, David Joyner stated in his opening statement at the 2023 Senate Insulin Hearing, "When people can afford their medications, like insulin, they are more likely to adhere to prescribed therapies.

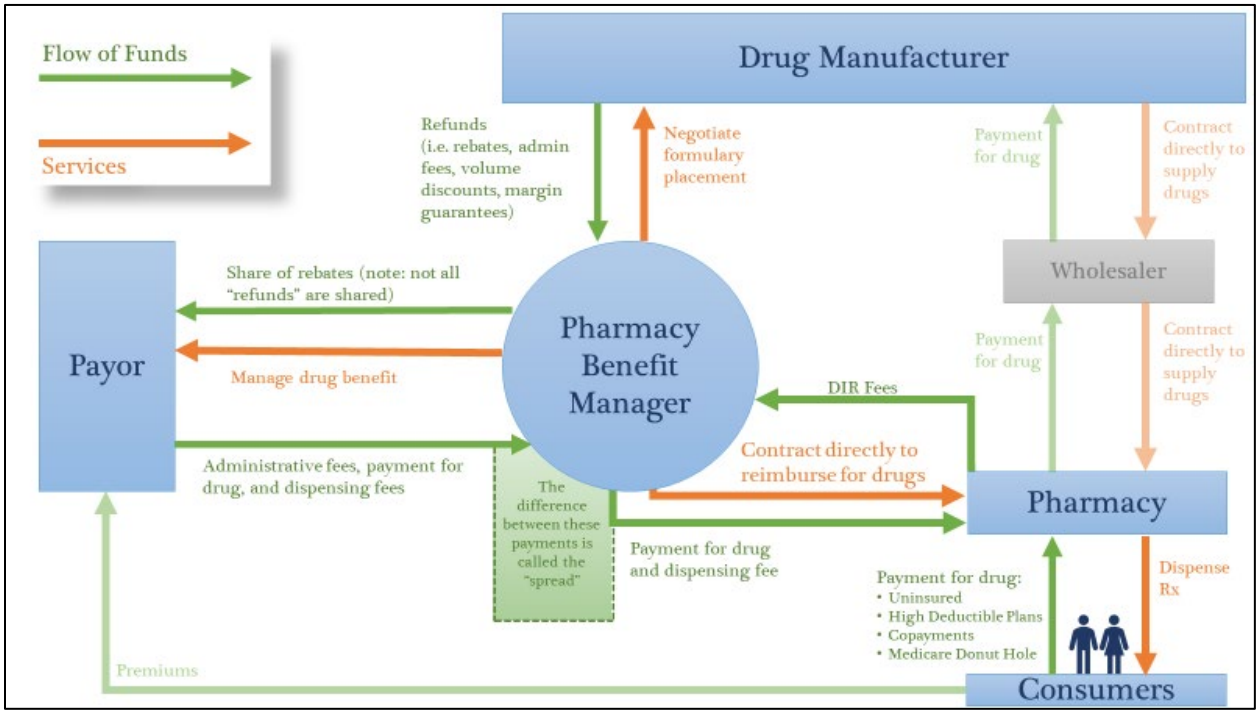
[32] Cefalu, W. et al., *Insulin Access and Affordability Working Group: Conclusions and Recommendations*, DIABETES CARE (May 2018), https://diabetesjournals.org/care/article/41/6/1299/36487/Insulin-Access-and-Affordability-Working-Group.

Adherence means better outcomes; better outcomes mean the health care system will spend far less on complications and hospitalizations."[33]

2. PBMs' role in the pharmaceutical payment chain

311. PBMs are at the center of the convoluted pharmaceutical payment chain, as illustrated in Figure 6:

Figure 6:
Insulin distribution and payment chain



312. The PBM Defendants' services directly influence the cost and access to diabetes medications for Virginia consumers, and the medications are consumed for personal use.

[33] *The need to make insulin affordable for all Americans: Hearing of the Comm. On Health, Edu., Labor, and Pensions U.S. Sen.*, 118th Cong. 118-198 (May 10, 2023), https://www.congress.gov/event/118th-congress/senate-event/LC72553/text.

313. The PBM Defendants develop the lists of drugs that Virginia consumers will be able to access, also called drug formularies; process pharmaceutical claims representing drugs dispensed to Virginia consumers; create a network of retail pharmacies at which Virginia consumers access the drugs; set the prices, in coordination with the Manufacturers, that Virginia consumers ultimately will pay directly and/or that insurance payors will pay for prescription drugs; and are paid by payors for the drugs that Virginia consumers take.

314. The PBM Defendants have consumer-facing websites representing that they "serve" consumers and that consumers are their "members."

315. The PBM Defendants further represent that giving consumers access to necessary prescription drugs at an affordable price is a top priority.

316. PBMs also contract with a network of retail pharmacies, including those pharmacies that are affiliated with the PBM. Pharmacies agree to dispense drugs to patients and pay fees back to the PBMs. PBMs reimburse pharmacies for the drugs dispensed.

317. PBM Defendants also own mail-order, retail and specialty pharmacies, which purchase and take possession of prescription drugs, including those at-issue here, and directly supply those drugs to patients.

318. Often times—including for the at-issue drugs—the PBM Defendants purchase drugs from the Manufacturers and dispense them to the patients.

319. Even where PBM Defendant's pharmacies purchase drugs from wholesalers, at times their costs are set by direct contracts with the Manufacturers.

320. In addition, and of particular significance here, PBM Defendants contract with pharmaceutical manufacturers, including Manufacturer Defendants.

321. These relationships allow PBMs to exert tremendous influence over what drugs are available throughout Virginia and at what prices.

322. Thus, PBMs are at the center of the flow of money in the pharmaceutical supply chain. In sum, the PBMs' services include at least the following:

a. they negotiate the price that insurance payors pay for prescription drugs (for the at-issue drugs based on artificially-inflated prices generated by the Insulin Pricing Scheme) and which sets the out-of-pocket costs paid directly by Virginia consumers for drugs for personal use;

b. they separately negotiate a different (and often lower) price that pharmacies in their networks receive for that same drug upon dispensing the drug to a Virginia consumer;

c. they set the amount in fees that the pharmacy pays back to the PBM for each drug sold to a Virginia consumer (for the at-issue drugs based on artificially-inflated prices generated by the Insulin Pricing Scheme);

d. they set the price paid for each drug sold through their mail order pharmacies to a Virginia consumer (for the at-issue drugs based on artificially-inflated prices generated by the Insulin Pricing Scheme); and

e. they negotiate the amount that the Manufacturers pay back to the PBM for each drug sold to a Virginia consumer (for the at-issue drugs based on artificially-inflated prices generated by the Insulin Pricing Scheme).

323. Yet, for the majority of these consumer transactions, only the PBMs are privy to the amount that any other entity in this pricing chain is paying or receiving for the exact same drugs.

324. In every interaction that PBMs have within the pharmaceutical pricing chain and every service they provide—interactions and services which culminate in the purchase and receipt of a drug by a Virginia consumer—they stand to profit from the artificially-inflated prices generated by the Insulin Pricing Scheme.

3. The rise of the PBMs in the pharmaceutical supply chain

325. When they first came into existence in the 1960s, PBMs functioned largely as claims processors. Over time, however, they have taken on a substantially larger role in the pharmaceutical industry. Today, PBMs wield significant control over the drug pricing system, and their services have direct consequences for Virginia consumers.

326. One of the roles PBMs took on was negotiating with drug manufacturers ostensibly on behalf of payors.

327. In the early 2000s, PBMs started buying pharmacies.

328. When a PBM combines with a pharmacy, it has increased incentive to collude with Manufacturers to keep certain prices high for payors and consumers.

329. These perverse incentives still exist today with respect to both retail and mail order pharmacies housed within the PBMs' corporate families, and both the retail and mail order pharmacies sell directly to individuals, including Virginia consumers.

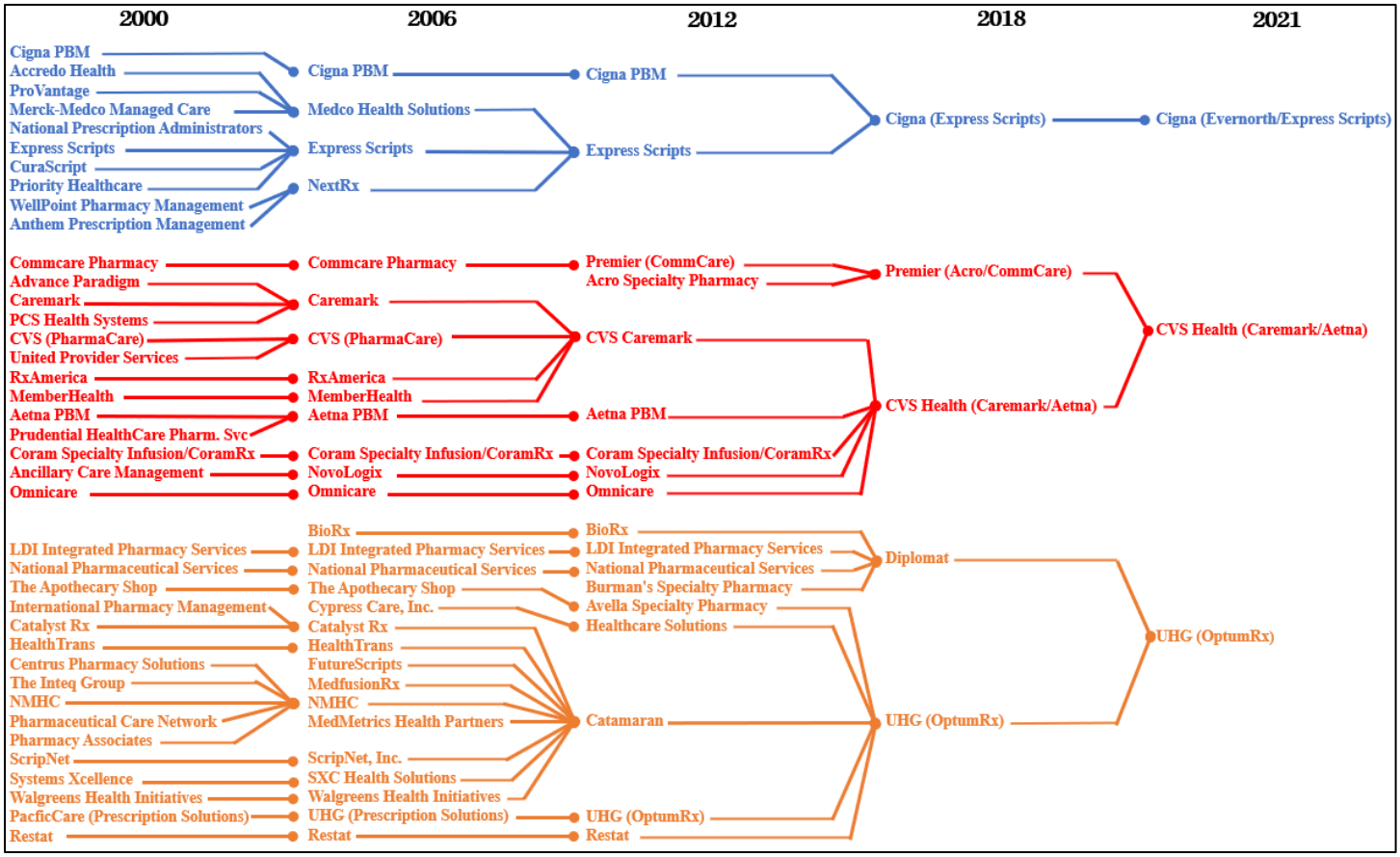
330. More recently, further consolidation in the industry has afforded PBMs a disproportionate amount of market power.

331. In total, nearly forty different PBM entities have merged or otherwise been absorbed into what are now the PBM Defendants.

332. In addition, each of the PBM Defendants are now owned by other significant players within the pharmaceutical chain: Express Scripts merged with Cigna in a $67 billion-dollar deal, Caremark was bought by the largest pharmacy in the United States, CVS for $21 billion; CVS also now owns Aetna following a $69 billion-dollar deal; and OptumRx is owned by the largest health insurance company in the United States, UnitedHealth Group.

333. Figure 7: PBM consolidation depicts this consolidation within the PBM market.

Figure 7:
PBM consolidation



334. After merging or acquiring all their competitors and now backed by multi-billion-dollar corporations, PBM Defendants have taken over the consumer drug market in the past decade.

335. The PBM Defendants control over 80% of the market and manage pharmacy benefits for over 270 million Americans.

336. Importantly, PBM Defendants have near *complete* control over the amounts Manufacturers pay in rebates, fees and other remuneration to ensure their drugs end up in the hands of the consumers via the PBMs' services. This is because, in addition to their own clients, most smaller pharmacy benefit managers—including

the largest pharmacy benefit manager in the United States outside the PBM Defendants, Prime Therapeutics—contract with the PBM Defendants (or their controlled affiliate rebate aggregator companies) to negotiate Manufacturer Payments on their behalf.

337. This control is profitable for PBM Defendants. Together, they report more than $300 billion in annual revenue.

338. PBMs are able to use the consolidation in the market as leverage when negotiating with other entities in the pharmaceutical pricing chain.

339. Industry expert Lindsay Bealor Greenleaf from the Advice and Vision for the Healthcare Ecosystem (ADVI) consulting described this imbalance in power: "it's really difficult to engage in any type of fair negotiations when one of the parties has that kind of monopoly power . . . I think that is something that is going to continue getting attention, especially as we see more of these payors and PBMs continue to try to further consolidate."[34]

4. Insular nature of the pharmaceutical industry

340. The insular nature of the PBM and pharmaceutical industry has provided PBM Defendants with ample opportunity for contact and communication amongst themselves, as well as with Manufacturer Defendants, in order to devise and agree to the Insulin Pricing Scheme.

[34] Minemyer, Paige, *Senate hearing puts spotlight on debate over consolidation in PBM Market*, FIERCE HEALTHCARE (Apr. 11, 2019), https://www.fiercehealthcare.com/payer/senate-hearing-puts-spotlight-debate-over-consolidation-pbm-market.

341. Each Manufacturer Defendant is a member of the Pharmaceutical Research and Manufacturers of America ("PhRMA") and has routinely communicated through PhRMA's meetings and platforms in furtherance of the Insulin Pricing Scheme.

342. Paul Hudson, CEO of Sanofi and Douglas Langa, Executive Vice President of Novo Nordisk, are part of the PhRMA board of directors and/or part of the PhRMA executive leadership team.

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

344. Each year during the relevant time period, the main PBM trade association, the Pharmaceutical Care Management Association ("PCMA"), held several yearly conferences, including its Annual Meeting and its Business Forum conferences.

345. During the relevant time period, the board of the PCMA has included executives from each PBM Defendant, including Amy Bricker, President of Express Scripts; Heather Cianfrocco, CEO of OptumRx; Alan Lotvin, Executive Vice President of CVS Health and President of CVS Caremark; John Prince, President and COO of Optum, Inc. (and former CEO of OptumRx); Jon Roberts, Executive Vice President of CVS Health; and Tim Wentworth, CEO of Evernorth.

346. All PBM Defendants are members of and, as a result of their leadership positions, control the PCMA. Each Manufacturer Defendant is an affiliate member of this organization.

347. The PCMA annual conferences appear to be at the center of the Insulin Pricing Scheme.

348. Every year, high-level representatives and corporate officers from both PBM and Manufacturer Defendants attend these conferences to meet in person to discuss their shared business opportunities within the pharmaceutical industry. Defendants also have used these conferences to engage in private meetings in furtherance of the Insulin Pricing Scheme.

349. In fact, all of the Manufacturer Defendants have recently been "Presidential Sponsors" of these PBM conferences.

350. Notably, 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.[35]

351. Representatives from each Manufacturer Defendant met privately with representatives from each PBM Defendant during both the Annual Meetings and Business Forum conferences that the PCMA held each year.

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[35] PCMA, NATIONAL MEETING 2021, https://web.archive.org/web/20230425194005/https://www.pcmanet.org/pcma-event/annual-meeting-2021/ (last visited Dec. 18, 2025).

352. Prior to these meetings dedicated teams of executives from each Defendant would spend weeks preparing PCMA "pre-reads" and reports in preparation for these meetings. These reports demonstrate the deep involvement of each Defendant in the Insulin Pricing Scheme.

353. In addition, all PCMA members, affiliates and registered attendees of these conferences are invited to join PCMA-Connect, "an invitation-only LinkedIn Group and online networking community." As PCMA members, PCMA-Connect provides PBM and Manufacturer Defendants with a year-round, non-public online forum to engage in private discussions in furtherance of the Insulin Pricing Scheme.

354. Notably, key at-issue lockstep price increases occurred shortly after the Defendants met at PCMA meetings.

355. For example, on September 26 and 27, 2017 the PCMA held its annual meeting, where each of the Manufacturer Defendants hosted private rooms and executives from each Defendant engaged in several meetings throughout the conference.

356. Several days after the conference, on October 1, 2017, Sanofi increased Lantus's list price by 3% and Toujeo's list by 5.4%. A few weeks later Novo Nordisk recommended that the company make a 4% list price increase on January 1, 2018, to match the Sanofi increase, which was approved November 3, 2017.

357. Likewise, on May 30, 2014, Novo Nordisk raised the list price of Levemir several hours after Sanofi made its list price increase on Lantus which occurred only

a few weeks after a PCMA spring conference in Washington DC attended by representatives from all the PBM Defendants.

358. Further, the PBMs control PCMA and have utilized it to further their interests and to hide the Insulin Pricing Scheme. PCMA has aimed to block drug pricing transparency efforts.

D. The Insulin Pricing Scheme

359. The market for the at-issue diabetes medications is unique in that it is highly concentrated with, until recently, little to no generic/biosimilar options and the drugs have similar efficacy and risk profiles. In fact, PBMs treat the at-issue drugs as consumer commodity goods in constructing their formularies.

360. In such a market, where manufacturing costs have significantly decreased, PBMs should have great leverage in negotiating with the Manufacturer Defendants to drive prices down for consumers, including Virginia consumers, in exchange for formulary placement.

361. The PBMs, however, do not want the prices for diabetes medications for consumers to go down because they make more money on higher prices. So do the Manufacturers.

362. As a result, Defendants have found a way to manipulate pricing for their mutual benefit—the Insulin Pricing Scheme.

363. PBM Defendants' formularies are at the center of the Insulin Pricing Scheme. Given the asymmetry of information and disparity in market power between payors and PBM Defendants, and the costs associated with making formulary changes, most payors accept the standard formularies offered by the PBMs.

364. Manufacturer Defendants recognize that, because PBM Defendants have such a dominant market share, if they chose to exclude a particular diabetes medication from their standard formularies (or give it a non-preferred position), it could mean billions of dollars in profit loss for Manufacturer Defendants when their drugs do not end up in the hands of consumers.

365. For example, Olivier Brandicourt, Sanofi's Chief Executive Officer, in an interview stressed the importance of the PBMs' standard formularies: "if you look at the way [CVS Caremark] is organized in the U.S . . . 15 million [lives] are part of [CVS Caremark's standard] formulary and that's very strict, all right. So, [if we were not included in CVS Caremark's standard formulary] we wouldn't have access to those 15 million lives."[36]

366. Each "life," of course, is a different individual consumer.

367. Manufacturer Defendants also recognize that the PBM Defendants profits are directly tied to the Manufacturers' list prices.

368. For example, the January 2021 Senate Insulin Report noted this in summarizing the internal documents produced by the Manufacturers:

> Novo Nordisk executives, when considering lower list prices, were sensitive to the fact that PBMs largely make their money on rebates and fees that are based on a percentage of a drug's list price . . . In other words, the drug makers were aware that higher list prices meant higher revenue for PBMs.[37]

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[36] Bank of America Merrill Lynch Global Health Conference, London, UK (Sept. 16, 2016), available at http://edge.media-server.com/m/p/7neehd6y.

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

369. The documents released by the Senate contemporaneous with the January 2021 Senate Insulin Report further corroborate the degree to which the Manufacturers' pricing strategy is focused on the PBMs' profitability.

370. In an internal August 6, 2015, email, Novo Nordisk executives debated delaying increasing the price of an at-issue drug in order 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 our increase . . . it has been costing CVS a good amount of money.[38]

371. The Manufacturer Defendants know that, contrary to their public representations, PBM Defendants make more money from *increasing* prices. Over the course of approximately the last fifteen years—and working in coordination with the PBMs—the Manufacturers have artificially inflated their list prices for the at-issue drugs exponentially, while largely maintaining their net prices by paying larger and larger amounts of Manufacturer Payments back to the PBMs.

372. Starting in 2011, the PBMs began constructing and implementing exclusionary formularies which accelerated the insulin price increases.

[38] *Id*. at App'x 3.

373. As a result, during approximately the last fifteen years, the amount of Manufacturer Payments paid to the PBMs has increased substantially. For example, the January 2021 Senate Insulin Report found that:

> In July 2013, Sanofi offered rebates between 2% and 4% for preferred placement on CVS Caremark's commercial formulary. Five years later, in 2018, Sanofi rebates were as high as 56% for preferred formulary placement. Similarly, rebates to Express Scripts and OptumRx increased dramatically between 2013 and 2019 for long-acting insulins. For example, in 2019, Sanofi offered OptumRx rebates up to 79.75% for Lantus for preferred formulary placement on their client's commercial formulary, compared to just 42% in 2015. Similarly, Novo Nordisk offered Express Scripts rebates up to 47% for Levemir for preferred formulary placement on their client's commercial formulary, compared to 25% in 2014.[39]

374. Beyond increased rebate demands, the PBMs have also requested and received larger administrative fee payments from the Manufacturers during the relevant time period.

375. 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.[40]

376. The value of these rebates and administrative fees to the PBMs was highlighted during a May 10, 2023, Congressional Hearing before the Senate Health, Education, Labor, and Pensions (HELP) Committee where Defendants testified

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[39] *Id.*

[40] *The Prescription Drug Landscape, Explored*, PEW (Mar. 8, 2019), https://www.pewtrusts.org/en/research-and-analysis/reports/2019/03/08/the-prescription-drug-landscape-explored.

entitled "The Need to Make Insulin Affordable for All Americans" ("2023 Senate Hearing").

377. During the 2023 Senate Hearing, the executives from the Manufacturer Defendants testified that $0.75 to $0.84 of every dollar spent on the list price of insulin goes directly to PBMs and their affiliated rebate aggregators—despite the rising out-of-pocket costs to diabetics.

378. In exchange for the Manufacturer Defendants inflating these prices and paying the PBMs substantial amounts in Manufacturer Payments, the PBM Defendants grant Manufacturer Defendants' diabetes medications with the most elevated price (and that are the most profitable to the PBMs) preferred status on their standard formularies.

379. At all times relevant hereto, the PBM Defendants have known that the list prices for the at-issue drugs are grossly inflated. Indeed, the Manufacturers' list prices have become so untethered from the Manufacturers' net prices[41] as to constitute unlawful deceptive prices.

380. Despite this knowledge, PBMs include the artificially-inflated list price—often the AWP price—in their contracts as a basis to set the rate that payors and patients pay for the at-issue drugs and pharmacies are reimbursed for the at-issue drugs.

[41] "Net Price" refers to the Manufacturers' list price minus all Manufacturer Payments paid to the PBMs.

381. Moreover, the PBMs also use the artificially-inflated list price to misrepresent the amount of "savings" they generate for diabetics, payors and the healthcare system.

382. For example, in January 2016, Express Scripts' president Tim Wentworth stated at the 34th annual JP Morgan Healthcare Conference that Express Scripts "saved our clients more than $3 billion through the Express Scripts National Preferred Formulary."[42]

383. Likewise, in April 2019, CVS Caremark President and Executive Vice President of CVS Health Corp. Derica Rice stated, "Over the last three years . . . CVS Caremark has helped our clients save more than $141 billion by blunting drug price inflation, prioritizing the use of effective, lower-cost drugs and reducing the member's out-of-pocket spend."[43]

384. The PBM Defendants also misrepresent the amount of "savings" they generate to their payor clients and prospective clients.

385. In making these representations, the PBMs fail to disclose that the amount of "savings" they have generated is calculated based on the artificially-inflated list prices, which are not paid by any entity in the pharmaceutical pricing chain and which the PBMs are directly responsible for inflating.

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[42] Surabhi Dangi-Garimella, PhD, *PBMs Can Help Bend the Cost Curve: Express Scripts' Tim Wentworth*, AJMC (Jan. 12, 2016), https://www.ajmc.com/view/pbms-can-help-bend-the-cost-curve-express-scripts-tim-wentworth.

[43] *CVS Health PBM Solutions Blunted the Impact of Drug Price Inflation, Helped Reduce Member Cost, and Improved Medication Adherence in 2018*, CVS HEALTH (Apr. 11, 2019), https://web.archive.org/web/20210525205837/https://www.cvshealth.com/news-and-insights/press-releases/cvs-health-pbm-solutions-blunted-the-impact-of-drug-price.

386. The PBM Defendants are not only favoring higher list price/higher Manufacturer Payment drugs on their formularies, but they also are excluding (or disadvantaging) lower priced diabetes drugs from their formularies.

387. Because the PBM Defendants control 80% of the market, this means that the PBM Defendants are effectively denying access to affordable diabetic treatments for 80% of the diabetics in Virginia.

388. One example of this conduct was discussed at the 2023 Senate Hearing, involving the insulin drug Semglee. In July 2021, the FDA designated Semglee as interchangeable with Lantus, meaning that Semglee could be substituted for Lantus at the pharmacy without the doctor writing a new prescription.

389. The drug manufacturer Viatris released Semglee at a 65% lower list price to Lantus, but was excluded from the PBM Defendants' formularies. Several years later, Viatris rereleased the exact same product, this time at a much higher list price (only 5% lower than Lantus). This time, the PBM Defendants allowed Semglee onto many of their formularies.

390. The global strategic consulting company, Xcenda, put out a report in May 2022 titled "Skyrocketing growth in PBM formulary exclusions continues to raise concerns about patient access" that found:

> Exclusions, potentially driven in part by misaligned [PBM Defendant] incentives, have had an extensive impact on patients' access to insulin over the study period. Lower list-priced insulins have been available since 2016—including follow-on insulins, "authorized generic" insulins, and, more recently, biosimilar insulins. However, [the PBM Defendants] often exclude these insulins from their formularies in favor of products with higher list prices and larger rebates. For example, 2 of the 3 [PBM

> Defendants] have excluded the 2 insulin authorized generics from their formulary exclusion lists since 2020, instead favoring the higher list-priced equivalents. Remarkably, this was true even though the list prices for these authorized generic insulins can be half the list price of the brand. In addition to the exclusions of authorized generic insulins, lower list-priced biosimilar insulins have also faced formulary exclusions. The first biosimilar insulin was launched in 2021. Due to prevailing market dynamics, 2 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 payers the option of which to cover. All 3 PBMs excluded the lower-list priced version in 2022, instead choosing to include the identical product with a higher list price.[44]

391. In July 2024, the Federal Trade Commission released its Interim Staff Report related to its investigation of the PBM Defendants titled, "Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies" ("FTC Interim PBM Report").

392. In the Report, the FTC shared "evidence that [the PBM Defendants] and brand pharmaceutical manufacturers sometimes enter agreements to exclude generic drugs and biosimilars from certain formularies in exchange for higher rebates from the manufacturers."

393. Two months later, on September 20, 2024, the FTC brought action against PBM Defendants and their affiliated rebate aggregators (Ascent, Emisar, Zinc) for engaging in "unfair rebating practices that have artificially inflated the list price of insulin drugs, impaired patients' access to lower list price goods, and shifted

[44] *Skyrocketing growth in PBM formulary exclusions continues to raise concerns about patient access*, XCENDA (May 2022), https://www.xcenda.com/-/media/assets/xcenda/english/content- assets/white-papers-issue-briefs-studies-pdf/xcenda_pbm_exclusion_may_2022.pdf.

the cost of high insulin list prices to vulnerable patients (referred to herein as the Insulin Pricing Scheme)."[45]

394. The Insulin Pricing Scheme is a coordinated effort between the Manufacturer and PBM Defendants, that each agreed to and participated in and that created enormous profits for all Defendants. For example:

a. Manufacturers and PBMs are in constant communication and regularly meet and exchange information to construct and refine the PBM formularies that 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 determining the same for competing goods;

b. Manufacturers and 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 construct their formularies in the manner that is most profitable for both sets of Defendants. The

[45] *Complaint, In the Matter of Caremark Rx, LLC, et al.*, No. 9437 (FTC), available at https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescription-drug-middlemen-artificially-inflating-insulin-drug-prices.

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; and

c. Manufacturers and 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.

395. Far from using their bargaining power to lower drug prices as they represent Defendants use their dominant positions to work together to generate billions of dollars at the expense of Virginia diabetics.

E. Defendants' Congressional Testimony

396. On April 10, 2019, the United States House of Representatives Committee on Energy and Commerce held a hearing on Defendants' Insulin Pricing Scheme titled, "Priced Out of a Lifesaving Drug: Getting Answers on the Rising Cost of Insulin."

397. Representatives from all Defendants testified at the hearing, and each acknowledged before Congress that the price for insulin has increased exponentially in the past fifteen years.

398. Representatives from each Defendant explicitly admitted that the price that diabetics have to pay out-of-pocket for insulin is too high. For example:

a. Dr. Sumit Dutta, Chief Medical Officer of OptumRx stated, "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."

b. Thomas Moriarty, Chief Policy and External Affairs Officer and General Counsel for CVS Health testified, "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, [list] prices for insulin have increased nearly 50 percent. And over the last ten years, [list] price of one product, Lantus, rose by 184 percent."

c. Kathleen Tregoning, Executive Vice President External Affairs at Sanofi, testified, "Patients are rightfully angry about rising out-of-pocket costs and we all have a responsibility to address a system that is clearly failing too many people. . . we recognize the need to address the very real challenges of affordability . . . Since

2012, average out-of-pocket costs for Lantus have risen approximately 60 percent for patients . . ."

d. Doug Langa, Executive Vice President of Novo Nordisk, stated, "On 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."

399. Notably, none of the testifying Defendants claimed that the significant increase in the price of insulin was related to competitive factors such as increased costs or improved clinical benefit.

400. None of the Defendants pointed to any other participant in the pharmaceutical pricing chain as responsible for the price increases for these diabetes medications. Nor could they, as these Defendants collectively (along with one additional insulin manufacturer) are responsible for the price of almost every single vial of insulin sold in the United States.

401. At the April 2019 Congressional hearing Novo Nordisk's President, Doug Langa, explained Novo Nordisk's and PBM Defendants' role in perpetuating the "perverse incentives" of the Insulin Pricing Scheme:

> [T]here is this perverse incentive and misaligned incentives (in the insulin pricing system) and this encouragement to keep [list] prices high. And *we've been participating in that system* because the higher the [list] price, the higher the rebate . . . There is a significant demand for rebates. We spend almost $18 billion in rebates in 2018 . . . [I]f we eliminate all the rebates . . . we would

> be in jeopardy of losing [our formulary] positions. (emphasis added).[46]

402. Sanofi has also conceded its participation in the Insulin Pricing Scheme. When testifying at the April 2019 Congressional hearing, Kathleen Tregoning, Executive Vice President for External Affairs of Sanofi, 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.[47]

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

404. Amy Bricker, President of Express Scripts, when asked to explain why Express Scripts did not grant an insulin with a lower list price preferred formulary status, answered, "Manufacturers do give higher [payments] for exclusive [formulary] position . . . ."[48]

405. While all Defendants acknowledged their participation in the Insulin Pricing Scheme before Congress, in an effort to avoid culpability for the precipitous price increase, each Defendant group assigned blame to the other as the responsible party.

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[46] *Priced Out of a Lifesaving Drug: Getting Answers on the Rising Cost of Insulin: Hearing before H. Comm. of Energy and Commerce*, 116th Cong. (Apr. 10, 2019), https://www.congress.gov/event/116th-congress/house-event/109299.

[47] *Id.*

[48] *Id.*

406. PBM Defendants specifically testified to Congress that Manufacturer Defendants are solely responsible for their price increases and that the Manufacturer Payments that the PBMs receive are not correlated to rising insulin prices.

407. This statement is objectively false. The Manufacturers' coordinated, lockstep price increases are a direct reflection of the PBMs' coordinated requests for larger Manufacturer Payments.

408. A February 2020 study by the Leonard D. Schaeffer Center for Health Policy & Economics at the University of South California titled "The Association Between Drug Rebates and List Prices," found that an increase in the amount that the Manufacturers pay back to the PBMs is directly correlated to an increase in prices—on average, a $1 increase in Manufacturer Payments is associated with a $1.17 increase in price—and that reducing or eliminating Manufacturer Payments could result in lower prices and reduced out-of-pocket expenditures.[49]

409. In addition, in a 2019 report the National Community Pharmacists Association estimated that Manufacturer Payments add nearly 30 cents per dollar to the price consumers pay for prescriptions.[50]

410. Further, in large part because of the increased list prices, and related Manufacturer Payments, PBMs' profit per prescription has grown exponentially over the same time period that insulin prices have been increasing.

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[49] Sood, N. et al., *The Association Between Drug Rebates and List Prices*, USC SCHAEFFER CENTER FOR HEALTH POLICY & ECONOMICS (Feb. 11, 2020), https://healthpolicy.usc.edu/research/the-association-between-drug-rebates-and-list-prices/.

[50] *The Truth About Pharmacy Benefit Managers: They Increase Costs and Restrict Patient Choice and Access*, NCPA (Sept. 2020), https://ncpa.org/sites/default/files/2020-09/ncpa-response-to-pcma-ads.pdf.

411. By way of example, since 2003 Defendant Express Scripts has seen its profit per prescription increase over 500 percent per adjusted prescription.

412. The Manufacturers, on the other hand, argued before Congress that the PBMs were to blame for high insulin prices because of their demands for higher Manufacturer Payments in exchange for formulary placement.

413. However, that also is not the whole picture. A 2020 study from the Institute of New Economic Thinking titled, "Profits, Innovation and Financialization in the Insulin Industry," demonstrates that Manufacturer Defendants are still making substantial profits from the sale of diabetes medications regardless of any Manufacturer Payments they are sending back to the PBMs.[51]

414. During the same time period, when insulin price increases were at their steepest, distributions to Manufacturers' shareholders in the form of cash dividends and share repurchases totaled $122 billion. In fact, during this time period the Manufacturers spent a significantly lower proportion of profits on research and development compared to shareholder payouts.

415. The January 2021 Senate Insulin Report concluded, *inter alia*:

a. Manufacturer Defendants are retaining more revenue from insulin than in the 2000;

[51] Collington, Rosie, *Profits, Innovation and Financialization in the Insulin Industry*, INSTITUTE FOR NEW ECON. THINKING (March 30, 2020), https://www.ineteconomics.org/uploads/papers/WP_120-Collington-The-insulin-industry.pdf

b. Manufacturer Defendants have aggressively raised the list price of their diabetes medications absent significant advances in the efficacy of the drugs; and

c. Manufacturer Defendants only spend a fraction of their revenue related to the at-issue drugs on research and development. For example, from 2016 to 2020, Novo Nordisk spent approximately $29 billion on stock buybacks and shareholder dividend payouts while only spending approximately $12 billion on R&D costs.

416. As discussed above, on May 10, 2023, Defendants again testified before Congress at the 2023 Senate Insulin Hearing. Each Defendant group once again blamed the other.

417. For example, Paul Hudson**,** CEO of Sanofi, said during the hearing: "Today, there are just three payors in the system that cover 80% of American lives . . . These consolidated entities encompass PBMs, health insurance, specialty pharmacies and group purchasing organizations. This vertical integration gives these corporations near total control over the goods patients can access and the price they have to pay."[52]

[52] *Examining the Need to Make Insulin Affordable for all Americans*, U.S. S. Comm. on Health, Edu., Labor, & Pensions, S. Hrg. 118-198 (May 10-11, 2023), available at https://www.govinfo.gov/content/pkg/CHRG-118shrg54476/pdf/CHRG-118shrg54476.pdf.; *see also NEWS: HELP Committee to Bring CEOs of Major Insulin Manufacturers and PBMs Together for Historic Hearing to Discuss the Need to Lower Insulin Prices and the Cost of Other Prescription Drugs*, U.S. S. Comm. on Health, Edu. Labor & Pensions (Apr. 21, 2023), https://www.help.senate.gov/chair/newsroom/press/news-help-committee-to-bring-ceos-of-major-insulin-manufacturers-and-pbms-together-for-historic-hearing-to-discuss-the-need-to-lower-insulin-prices-and-the-cost-of-other-prescription-drugs.

418. Adam Kautzner, president of Express Scripts, had this to say during the hearing: "Drug manufacturers seek the highest price point possible and exploit the patent system and marketing practices to maintain monopoly status for their brands," and "For employers sponsoring high-deductible health plans, restrictions prevent lowering costs for patients before meeting their deductible."[53]

419. The PBM Defendants also continued to misrepresent that their conduct lowers insulin prices. For example, Adam Kautzner testified, "Without the ability to use [rebates] to achieve lower drug costs, health care spending would be much higher."[54]

420. The truth is, despite their attempts to evade responsibility in front of Congress, Manufacturers and PBMs are both responsible for their concerted efforts in creating the Insulin Pricing Scheme.

421. This reality was echoed in the statement from the Senate Insulin Report, summarizing Congress's findings of their two-year probe into the Insulin Pricing Scheme:

> [M]anufacturers and [PBMs] have created a vicious cycle of price increases that have sent costs for patients and taxpayers through the roof . . . This industry is anything but a free market when PBMs spur drug makers to hike list prices in order to secure prime formulary placement and greater rebates and fees.[55]

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[53] *Id.*

[54] *Id.*

[55] U.S. S. Fin. Comm., *Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug*, (Jan. 14, 2021), https://www.finance.senate.gov/chairmans-news/grassley-wyden-release-insulin-investigation-uncovering-business-practices-between-drug-companies-and-pbms-that-keep-prices-high.

F. Defendants Profit Off the Insulin Pricing Scheme

1. Manufacturers Profit Off Insulin Pricing Scheme

422. For Manufacturer Defendants, the Insulin Pricing Scheme affords them the ability to pay the PBM Defendants significant undisclosed Manufacturer Payments in exchange for formulary placement, without decreasing their profit margins.

423. During the relevant time period, PBM Defendants granted preferred formulary position to each at-issue drug in exchange for large Manufacturer Payments and inflated prices.

424. In addition, the Manufacturers coordinated with the PBM Defendants to exclude lower-priced diabetes medications from the PBMs' formularies because increasing sales and utilization of higher-priced diabetes medications is more profitable.

425. 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.

2. PBMs Profit Off Insulin Pricing Scheme

426. Because of the increased list prices, and related Manufacturer Payments, PBMs' profit per prescription has grown exponentially during the relevant time period.

427. A study published in the Journal of the American Medical Association titled, "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" concluded that the amount of money that goes to the PBM Defendants for each insulin prescription increased over 150% from 2014 to 2018.[56]

428. In fact, for transactions where the PBM Defendants control the insurer, the PBM and the pharmacy (i.e. Aetna-Caremark-CVS pharmacy), these Defendants now capture 50% of the money spent on each insulin prescription (up from only 25% in 2014), despite the fact that they do not contribute to the development, manufacture, innovation or production of the product.

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

a) PBMs profit off Manufacturer Payments

430. The first way in which the PBMs profit off the Insulin Pricing Scheme is by keeping a significant portion of the Manufacturer Payments.

431. The amount that the Manufacturers pay back to the PBMs has accelerated to represent a large percentage of the list price of diabetes medications.

[56] Van Nuys, Karen, PhD 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), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2785932.

432. Historically, when PBMs contracted with payors, the contract allowed the PBM to keep all or at least some of the Manufacturer Payments they received, rather than pass them along to the payor and/or diabetic.

433. Over time, payors have secured contract provisions guaranteeing them all or some portion of the "rebates" paid by the Manufacturers to the PBMs. Critically, though, "rebates" are only a portion of the total Manufacturer Payments.

434. In this regard, PBM and Manufacturer Defendants have created a "hide-the-ball" system where the consideration exchanged between them (and not shared with payors and diabetics) is labeled and relabeled.

435. As more payors moved to contracts that required PBMs to pass a majority of the manufacturer "rebates" through to the payor, PBMs have begun renaming the Manufacturer Payments in order to keep a larger portion of this money. Payments once known as "rebates" are now called administrative fees, volume discounts, service fees, inflation fees or other industry jargon terms designed to obfuscate and distract from the substantial sums being exchanged.

436. These renamed Manufacturer Payments are indeed substantial. A heavily redacted complaint filed by Defendant Express Scripts revealed that *Express Scripts now retains up to 13 times more in "administrative fees" than it passes through to payors in formulary rebates.*[57]

437. On June 17, 2022, the Federal Trade Commission ("FTC") voted 5-0 to issue a policy statement expressing its intent to closely scrutinize such PBM

[57] *Express Scripts, Inc., et al. v. Kaleo, Inc.*, Case No. 4:17-cv-01520-RLW (E.D. Mo 2017).

Defendants' conduct related to Manufacturer Payments to determine if these practices constitute unfair and deceptive practices.

438. In its policy statement, the FTC cited specifically to the effect that Manufacturer Payments have in the context of the high insulin prices and the devastating impact such practices have on the lives of diabetics.[58]

439. In addition, the PBMs have come up with numerous methods to hide these renamed Manufacturer Payments in order keep them for themselves.

440. For example, through Manufacturer Payments known as "inflation fees," the PBMs 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.

441. In particular, the Manufacturer Defendants often pay the PBM Defendants "inflation fees" in exchange for increasing their prices of their diabetes medications. The thresholds for these payments are typically set around 6% to 8%—if the Manufacturer Defendants raise their prices by more than 6% or 8% during a specified time period, they pay the PBM Defendants an additional "inflation fee" (based on a percentage of the artificially-inflated prices).

442. For many of their clients, the PBMs have separate "price protection guarantees" that state that if the overall drug prices for that payor increase by more

[58] FED. TRADE COMM'N, Policy Statement of the Federal Trade Commission on Rebates and Fees in Exchange for Excluding Lower-Cost Drug Products (2022), https://www.ftc.gov/system/files/ftc_gov/pdf/Policy%20Statement%20of%20the%20Federal%20Trade%20Commission%20on%20Rebates%20and%20Fees%20in%20Exchange%20for%20Excluding%20Lower-Cost%20Drug%20Products.near%20final.pdf.

than a set amount, then the PBMs will revert a portion of that amount back to these clients.

443. The PBMs set these "price protection guarantees" at a higher rate than the thresholds that trigger the Manufacturers' "inflation fees," usually around 12%-15%.

444. 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 can keep 100% of these "inflation fee" payments. This is a win-win for the Manufacturers and PBMs—they get to mutually retain and share all of the benefits of these price increases.

445. Another method that the PBMs have devised to hide the renamed Manufacturer Payments is through the use of rebate aggregators. Rebate aggregators, sometimes referred to as rebate group purchasing organizations ("GPOs"), are entities that negotiate for and collect Manufacturer Payments from drug manufacturers, including the Manufacturers, on behalf of a large group of pharmacy benefit managers (including the PBM Defendants) and different entities that contract for pharmaceutical drugs.

446. These rebate aggregators are often owned and controlled by the PBM Defendants, such as Ascent Health Services (Express Scripts); Coalition for Advanced Pharmacy Services and Emisar Pharma Services (OptumRx); and Zinc Health (CVS Caremark).

447. With respect to Ascent Health, the PBM Prime Therapeutics is a minority owner along with Express Scripts. Ascent negotiates Manufacturer Payments for the majority (if not all) of Prime Therapeutics' covered lives.

448. The PBMs carefully guard the revenue streams from their rebate aggregator activities, hiding them in complex contractual relationships and not reporting them separately in their quarterly SEC filings.

449. Certain rebate aggregator companies are located offshore, in Switzerland (Express Scripts' Ascent Health) and in Ireland (OptumRx's Emisar Pharma Services), for example, making oversight even more difficult.

450. These rebate aggregator entities generate additional and new Manufacturer Payments for the PBM Defendants from new administrative fees; prescription data services; data portals; enterprise fees; and other sources—all based on a percentage of drug list prices. These are revenues earned in addition to the PBM Defendants' typical administrative service fees.

451. The PBM Defendants use Zinc Health, Emisar Pharma, and Ascent Health to retain these new Manufacturer Payment fees. These new rebate aggregator fees have become a substantial source of profits for the PBMs and their affiliates, and are yet another driver of higher drug prices.

452. The *New York Times* recently published an investigation titled, "The Opaque Industry Secretly Inflating Prices for Prescription Drugs: Pharmacy benefit

managers are driving up drug costs for millions of people, employers and the government" ("NYT PBM Investigation").[59]

453. The NYT PBM Investigation found that "in 2022, PBMs and their [rebate aggregator affiliates] pocketed $7.6 billion in fees, double what they were bringing in four years earlier."[60]

454. The NYT PBM Investigation included a quote from an OptumRx executive that admitted the purpose behind the creation of these rebate aggregator entities:

> "The intention of the [rebate aggregator entities] is to create a fee structure that can be retained and not passed on to a client," said Kent Rodgers, a former OptumRx executive who helped set up Emisar, "A PBM has to keep some level of income for them to grow and satisfy stockholders."[61]

455. Moreover, during the relevant time period the PBM Defendants have used their affiliate rebate aggregator entities to increase their profits.

456. For example, a 2017 audit conducted by a local governmental entity on Defendant OptumRx related to its PBM activities from January 1, 2013 until December 31, 2015 concluded that the auditor was unable to verify the percentage of rebates OptumRx passed through 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

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[59] Robbins, Rebecca, *The Opaque Industry Secretly Inflating Prices for Prescription Drugs*, NEW YORK TIMES (June 21, 2024), https://www.nytimes.com/2024/06/21/business/prescription-drug-costs-pbm.html.

[60] *Id*.

[61] *Id*.

> 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 aggregator.[62]

457. 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."[63]

458. In other words, according to this audit report, OptumRx contracts with its own affiliate rebate aggregator, Coalition for Advanced Pharmacy Services, who then contracts with Express Scripts, who then contracts with the Manufacturers, for rebates related to OptumRx's client's drug utilization. OptumRx uses this complex relationship between itself, its affiliate, and the Manufacturers to obscure the amount of Manufacturer Payments that are being generated from its clients' utilization.

459. The January 2021 Senate Insulin Report contained the following observation on these rebate aggregators:

> [I]t is noteworthy that industry observers have suggested that the 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

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[62] Melton, Robert, *Audit of Pharmacy Benefit Management Services Agreement*, BROWARD CNTY. AUDITOR (DEC. 7, 2017), https://cragenda.broward.org/docs/2018/CCCM/20180109_555/25990_2017_1212%20Exh1_OptumRx%20-%20Revised%20Item.pdf.

[63] *Id*.

> 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.[64]

460. In May 2023, the FTC broadened the PBM FTC Inquiry to include the PBM Defendants' affiliated rebate aggregators.

461. On April 19, 2024, the Inspector General of the US Office of Personnel Management (OPM) published its final audit report of Express Scripts' management of the pharmacy benefit of the America Postal Workers Union Health Plan (the "Carrier") from 2016 to 2021.[65]

462. The audit found that Express Scripts overcharged the Carrier nearly $44.9 million by not passing through all Manufacturer Payments required under the contract, which included Ascent Health withholding approximately $15.8 million in Manufacturer Payments that should have been passed through to the Carrier.[66]

463. In July 2024, CVS Caremark agreed to pay the State of Illinois $45 million for Manufacturer Payments collected by Zinc Health that should have been passed through to the State of Illinois's health plan.

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

[65] Off. Inspector Gen. (OIG), *Audit of the American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2016 through 2021*, No. 2022-SAG-029, (Mar. 27, 2024) https://www.oversight.gov/sites/default/files/documents/reports/2024-10/2022-SAG-029.pdf.

[66] *Id.*

464. The NYT PBM Investigation also discussed the role of the PBM Defendants' rebate aggregator entities in the Insulin Pricing Scheme:

> A former executive of a major drug company, whose responsibilities included negotiating with [PBM Defendants' rebate aggregators], said that he had a set pool of money to cover fees to [PBM Defendants' rebate aggregators] and rebates to employers. When he paid more in fees, he offered less in rebates. Employers are none the wiser. They receive rebates. But they can't see the billions of dollars in fees that the [PBM Defendants' rebate aggregators] take for themselves.[67]

465. Because the PBMs are able to hide (and retain) a majority of the Manufacturer Payments that they receive, they are able to make significant profits on the Insulin Pricing Scheme.

b) PBMs profit off pharmacies

466. A second way that PBM Defendants profit off the Insulin Pricing Scheme is by using the artificially-inflated price generated by the scheme with the pharmacies with whom they contract, including those in Virginia.

467. PBM Defendants decide which pharmacies are included in the PBM's network and how much they will reimburse these pharmacies for each drug dispensed.

468. PBMs pocket the spread between the amount that the PBMs get paid by their clients for the at-issue drugs (which is based on the artificially-inflated prices generated by the Insulin Pricing Scheme) and the amount the PBM reimburses the pharmacy.

[67] Robbins, Rebecca, *The Opaque Industry Secretly Inflating Prices for Prescription Drugs*, NEW YORK TIMES (June 21, 2024), https://www.nytimes.com/2024/06/21/business/prescription-drug-costs-pbm.html.

469. PBMs do not disclose to their clients or network pharmacies how much the PBM is receiving from or paying to the other.

470. This spread pricing, like the Manufacturer Payment negotiation, happens behind closed doors. There is no transparency, no commitment from PBM Defendants to take into account 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.

471. The higher the Manufacturers inflate their prices, the more money the PBMs make off this spread, and the more diabetic consumers are adversely impacted by inflated prices.

472. PBMs also use the Insulin Pricing Scheme to generate additional profits from pharmacies by charging the pharmacies post-purchase fees, including DIR fees[68], based on the artificially-inflated prices generated by the Scheme. The higher the list price for each diabetes medication sold, the more the PBMs generate in these pharmacy fees.

c) Insulin Pricing Scheme increases PBM mail order and retail pharmacy profits

473. A third way PBMs profit off the Insulin Pricing Scheme is through the PBM Defendants' own mail order and retail pharmacies.

474. As explained above, the PBM Defendants are vertically integrated corporate families that include both PBM entities and mail order/specialty/retail pharmacies (among other entities):

[68] "DIR" fees are post-purchase concessions pharmacies pay back to the PBMs.

a. Express Scripts (PBM) is affiliated with Accredo (specialty pharmacy) and mail order pharmacies (including Defendant Express Scripts Pharmacy);

b. CVS Caremark (PBM) is affiliated with CVS Specialty Pharmacy (specialty pharmacy), mail order pharmacies, and Defendant CVS Pharmacy (retail); and

c. OptumRx is affiliated with mail order and specialty pharmacies.

475. By owning their own pharmacies, the PBM Defendants are able to steer their clients' prescription-drug plans to those pharmacies, including by requiring and/or incentivizing their covered lives to utilize their own mail order and retail pharmacies.

476. As stated in the NYT PBM Investigation: the PBM Defendants "push, and sometimes force, patients to use their pharmacies, whether mail-order or, in [CVS Pharmacy's] case, the physical drugstores."[69]

477. In June 2024, the House Committee on Oversight and Accountability released a report titled "The Role of Pharmacy Benefit Managers in Prescription Drug Markets" ("2024 House Committee PBM Report").

478. The 2024 House Committee PBM Report found that the PBM Defendants steer patients to their own pharmacies, including CVS Pharmacy and Express Scripts Pharmacy:

[69] Robbins, Rebecca, *The Opaque Industry Secretly Inflating Prices for Prescription Drugs*, NEW YORK TIMES (June 21, 2024), https://www.nytimes.com/2024/06/21/business/prescription-drug-costs-pbm.html.

> The three largest PBMs [including the PBM Defendants] each own retail, mail-order, and specialty pharmacies that are "preferred" in-network under the pharmacy benefit. PBMs steer patients to pharmacies they own by various means, including: (1) preventing patients from receiving 90-day prescriptions at competing pharmacies; (2) abusing data received by the PBM to target patients with highly profitable medications; (3) only covering specialty medications if they are dispensed from a particular pharmacy; and (4) charging patients higher copays at competing pharmacies to incentivize patients to use the PBM owned pharmacy. [Such practices] harms patients and independent community pharmacies, increasing drug prices for patients, employers, and government payers.[70]

479. In addition, the State of Minnesota recently levied a large fine against CVS Caremark for steering patients to its captured pharmacies, including by "[f]orcing a family to drive more than 100 miles or use a mail-order service to refill an insulin prescription." [71]

480. Once the PBM Defendants steer patients to their affiliated pharmacies, they are overcharging them for the at-issue drugs.

481. The higher the price that PBM Defendants are able to get their customers, such as Virginia diabetics, to pay for diabetes medications, the higher the profits PBM Defendants realize through their mail order and retail pharmacies.

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[70] H. Comm. on Oversight and Accountability, Staff Report, The Role of Pharmacy Benefit Managers in Prescription Drug Markets, (Jul. 2024), https://oversight.house.gov/wp-content/uploads/2024/07/PBM-Report-FINAL-with-Redactions.pdf; U.S. Fed. Trade Comm'n, Interim Staff Rep., *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies*, (Jul. 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf.

[71] *Commerce fines CVS Caremark $500,000 after 2022 case alleging violations of Pharmacy Benefit Manager Act*, MINNESOTA COMMERCE DEPARTMENT (May 1, 2023), https://mn.gov/commerce/news/?id=17-575233

482. Because the PBMs base the price they charge for the at-issue diabetes medications on the list price, the more the Manufacturers inflate these prices, the more money the PBMs make at their captive pharmacies.

483. A June 2024 study by Three Axis Advisors, a PBM research and investigation firm, found that the PBM Defendants are charging significantly higher prices at their captive pharmacies for branded drugs, such as the at-issue diabetes medications, than for those prescriptions filled by independent pharmacies. This is demonstrated by the Figure 8:

Average Markups for Medicines Dispensed through Mail Order versus other channels (Mean Margin = green; Median Margin = blue)[72]:

[72] Three Axis Advisors, *Understanding Drug Pricing from Divergent Perspectives*, (June 2024), https://static1.squarespace.com/static/5c326d5596e76f58ee234632/t/667a03dc16a9fb18a1b13614/1719272422304/3AA_Washington_Report_20240620.pdf

Figure 8:
Average Markups for Medicines Dispensed through Mail Order versus other channels
(Mean Margin = green; Median Margin = blue)

484. PBMs also collect and retain Manufacturer Payments tied directly to drugs dispensed by their captive pharmacies such as pharmacy supplemental discount fees; indirect purchase fees; and rebates.

485. The PBM Defendants do not pass these pharmacy Manufacturer Payments through to their clients.

486. These pharmacy Manufacturer Payments are based on the list price, thus the higher the price, the more profits the PBM Defendants make.

487. Another way the PBMs generate pharmacy profits from the inflated prices generated by the Insulin Pricing Scheme is by way of an arbitrage purchase strategy.

488. Because of their coordinated efforts with the Manufacturers in furtherance of the Insulin Pricing Scheme, the PBMs often know when the Manufacturers are going to raise their prices. The PBMs use this knowledge to purchase large quantities of the at-issue drugs prior to the price increases. The PBMs then charge diabetic consumers and payors the higher price after the increase.

489. During the relevant time period, the PBM Defendants' mail order and retail pharmacies dispensed the at-issue drugs to, and were paid by, Virginia diabetics based on the inflated list prices generated by the Insulin Pricing Scheme.

490. In sum, every way that the PBMs make money on diabetes medications is directly tied to the artificially-inflated list prices generated by the Insulin Pricing Scheme. PBMs are not lowering the price of diabetes medications as they publicly represent—rather they are making billions of dollars by fueling these increasing prices.

G. Defendants Deceived Virginia Diabetics

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

1. Manufacturer Defendants deceived Virginia Diabetics

492. At all times during the relevant time period, Manufacturer and PBM Defendants knew that diabetics were impacted by the artificially-inflated list prices

generated by the Insulin Pricing Scheme to pay for the at-issue drugs, and purchased diabetic medications at such prices.

493. Manufacturer and PBM Defendants knew that Virginia diabetics expected and desired to pay the lowest fair-market price possible for the at-issue drugs.

494. Manufacturer and PBM Defendants knew that the artificially-inflated list prices generated by the Insulin Pricing Scheme were false and completely untethered from the net prices that the Manufacturer Defendants were paid for the drugs.

495. As the list prices for the at-issue drugs detached completely from actual prices, the list prices became increasingly misrepresentative to the point of becoming unlawful.

496. Despite this knowledge, Manufacturer Defendants caused the artificially-inflated list prices generated by the Insulin Pricing Scheme to be published throughout Virginia through publishing compendia and in various promotional and marketing materials distributed by entities downstream in the drug supply chain.

497. Manufacturer Defendants also published these prices to the PBMs and their pharmacies who then knowingly use these false prices to set the amount diabetics pay for the at-issue drugs.

498. By publishing their prices throughout Virginia, the Manufacturers held these prices out as a reasonable price by which to base the prices diabetics pay for the at-issue drugs.

499. Manufacturer Defendants knew that their artificially-inflated list prices were not remotely related to the net price they received for the at-issue drugs and were not based on transparent or competitive factors such as cost of production or research and development.

500. The Manufacturer Defendants could have reported and published prices that accurately reflected the actual, net prices of the at-issue diabetes medications. However, in furtherance of, and in order to conceal, the Insulin Pricing Scheme the Manufacturer Defendants deliberately published only the artificially-inflated prices.

501. Notably, during the relevant time period, the Manufacturers published prices in Virginia of $300-$400 for the same at-issue drugs they could have priced at substantially lower prices.

502. Manufacturer Defendants have also 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 and research. During the relevant time period, executives from Sanofi and Novo Nordisk represented that research and development costs were key factors driving the at-issue price increases.

503. These statements are false. The Manufacturers only spend a fraction of their revenue on research and development for diabetes medications.

504. For example, Novo Nordisk has spent triple the amount it spends on R&D on stock buyouts and shareholder dividend payouts in recent years.

505. The 2021 Senate Report also concluded that Sanofi's R&D spending on Lantus, Soliqua, Toujeo, Apidra, and one other diabetes medication accounted for a

"fraction of the company's reported revenue from its diabetes franchise" between 2014-2018.[73]

506. The Manufacturers' list prices were artificially inflated in furtherance of the Insulin Pricing Scheme, to exclude diabetics' access to lower priced medications, and to generate profits for the Manufacturer and PBM Defendants.

507. Manufacturer Defendants affirmatively withheld the truth from Virginia diabetics and specifically made these misrepresentations in furtherance of the Insulin Pricing Scheme.

2. PBM Defendants deceived Virginia diabetics

508. PBM Defendants have deceived diabetics in Virginia.

509. PBM Defendants ensured that the Manufacturers' artificially-inflated list prices harmed diabetics by requiring that their contracts with both pharmacies and with payors include such prices as the basis for payment.

510. PBMs 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 therefrom.

511. Throughout the relevant time period, PBM Defendants have consistently and repeatedly represented that: (a) their interests are aligned with diabetics and payors; (b) they work to lower the price of the at-issue drugs and, in doing so, they

[73] *Id.*

achieve substantial savings for diabetics and payors; and (c) that the PBMs construct formularies designed to improve the health of diabetics.

512. PBMs understand that diabetics expect the PBMs to achieve the lowest prices for the at-issue drugs and to construct formularies designed to improve their health.

513. At no time have the PBM Defendants disclosed their knowledge of the artificially-inflated list prices for the at-issue drugs; to the contrary, the PBMs ensured that diabetics pay based on those artificially-inflated list prices.

514. In addition to the general PBM misrepresentations discussed above in the Parties section, throughout the relevant time period, PBM Defendants have purposefully, consistently, and routinely made misrepresentations specifically about the at-issue Manufacturer Payments; formulary construction; and the PBMs' role in the diabetic pricing system.

515. In a public statement issued on May 11, 2010, CVS Caremark represented that it was focused on diabetes to help add value for its PBM clients and improve the health of plan members. Stating that 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.[74].

[74] Chain Drug Review, *CVS expands ExtraCare for diabetes products*, (May 11, 2010), https://www.chaindrugreview.com/cvs-expands-extracare-for-diabetes-products/

516. On June 22, 2010, Andrew Sussman, Chief Medical Officer of CVS Caremark stated on national television that "CVS [is] developing programs to hold down [diabetes] costs."[75]

517. In a public statement issued in November 2012, CVS Caremark represented that formulary decisions related to diabetes medications "is one way the company helps manage costs for clients."[76]

518. On August 31, 2016, Glen Stettin, Senior Vice President and Chief Innovation Officer at Express Scripts released a statement that stated "[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."[77]

519. Mr. Stettin continued on to represent 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 drugs."[78]

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[75] CBS News, *Diabetes Epidemic Growing* (Jun. 22, 2010), https://www.cbsnews.com/news/diabetes-epidemic-growing/.

[76] Jon Kamp and Peter Loftus, *CVS' PBM Business Names Drugs It Plans to Block Next Year,* WALL STREET JOURNAL (Nov. 8, 2012), https://www.wsj.com/articles/SB10001424127887324439804578107040729812454.

[77] Angela Mueller, *Express Scripts launches program to control diabetes costs,* ST. LOUIS BUSINESS JOURNAL (Aug. 31, 2016), https://www.bizjournals.com/stlouis/news/2016/08/31/express-scripts-launches-program-to-control.html.

[78] Michael Johnsen, *Express Scripts implements latest Diabetes Care Value Program,* DRUG STORE NEWS (Aug. 31, 2016), https://drugstorenews.com/pharmacy/express-scripts-implements-latest-diabetes-care-value-program

520. In January 2017, Tim Wentworth, CEO of Express Scripts represented that "without PBMs, and specifically without Express Scripts, our clients would pay [many times] more for [insulin]."

521. Mr. Wentworth continued on to state Express Scripts is dedicated to controlling insulin prices because "we stand up for payers and patients."

522. In December 2016, Mark Merritt, President of the PCMA, in response to a question about PBMs' role in the insulin pricing system stated that PBMs leverage their formularies to pressure on drug companies to reduce insulin prices and aid patients.[79]

523. On April 3, 2019, Steve Miller Express Scripts' chief medical officer stated that Express Scripts "give[s] people who rely on insulin greater affordability and cost predictability so they can focus on what matters most: their well-being. Dr. Miller continued on to describe Express Scripts' work on behalf of diabetics as, "[b]etter care and better outcomes are rooted in greater choice, affordability, and access, and we can bring all of these to people with the greatest needs."[80]

524. CVS Caremark's Chief Policy and External Affairs Officer testified during 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

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[79] Dave Muoio, *Insulin Prices: Are PBMs and Insurers Doing Their Part?,* HMP GLOBAL LEARNING NETWORK (Dec. 2016), https://www.hmpgloballearningnetwork.com/site/frmc/article/insulin-prices-are-pbms-and-insurers-doing-their-part.

[80] *Cigna and Express Scripts Introduce Patient Assurance Program to Cap Out of Pocket Costs at $25 per 30-day Insulin Prescription*, CIGNA, (April 3, 2019) available at https://newsroom.cigna.com/cigna-and-express-scripts-introduce-patient-assurance-program-to-cap-out-of-pocket-costs-at-25-per-30-day-insulin-prescription.

off the manufacturers' price on behalf of employers, unions, government programs, and beneficiaries that we serve."[81]

525. 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 discounts off list prices on behalf of our customers."[82]

526. The PCMA website states, "the insulin market is consolidated, hindering competition and limiting alternatives, leading to higher list prices on new and existing brand insulins. PBMs work hard to drive down costs using formulary management and rebates."[83]

527. In August 2022, Heather Cianfrocco, CEO of OptumRx, stated that "[t]he need for affordable insulin is urgent, especially for uninsured populations" and represented that OptumRx can improve access and lower costs for those who need an

[81] House Energy and Commerce Subcommittee on Oversight and Investigations, House Committee Hearing: *Priced Out of a Lifesaving Drug: Getting Answers on the Rising Cost of Insulin* (Apr. 10, 2019), https://www.congress.gov/event/116th-congress/house-event/109299.

[82] *Id.*

[83] *PBM Savings on Insulin: Managing Costs with Increasing Manufacturer Prices*, PCMA, (Oct. 24, 2020), https://web.archive.org/web/20201024225737/https://www.pcmanet.org/insulin-managing-costs-with-increasing-manufacturer-prices/; *See also* PCMA, *PCMA on National Diabetes Month: PBMs Lowering Insulin Costs, Providing Support to Patients*, (Nov. 16, 2020), https://www.pcmanet.org/pcma-on-national-diabetes-month-pbms-lowering-insulin-costs-providing-support-to-patients/;
Visante on behalf of PCMA, *Insulins: Managing Costs with Increasing Manufacturer Prices* (Aug. 2020), https://www.pcmanet.org/wp-content/uploads/2020/08/PCMA_Visante-Insulins-Prices-and-Costs-.pdf

affordable insulin solution.[84] OptumRx also reiterated that it leverages its core clinical and pharmacy benefit capabilities to negotiate lower prices and discounts.[85]

528. PBM Defendants also misrepresented that they negotiate with Manufacturer Defendants to lower the price of the at-issue diabetes medications for diabetic *patients*.

529. Express Scripts' publicly available code of conduct states, "[a]t 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."[86]

530. Amy Bricker, President at Express Scripts 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."[87]

531. Amy Bricker of Express Scripts also testified at the Congressional hearing that "Express Scripts remains committed to . . . patients with diabetes and creating affordable access to their medications."[88]

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[84] UnitedHealth Group, *Optum to Offer Lower-Cost Insulin for Uninsured People Living With Diabetes on Optum Store*, (Aug. 1, 2022), https://www.unitedhealthgroup.com/newsroom/2022/2022-08-01-optum-offers-lower-cost-insulin-for-uninsured.html.

[85] *Id.*

[86] Express Scripts, *Code of Conduct,* https://www.express-scripts.com/aboutus/codeconduct/ExpressScriptsCodeOfConduct.pdf.

[87] House Energy and Commerce Subcommittee on Oversight and Investigations, House Committee Hearing: *Priced Out of a Lifesaving Drug: Getting Answers on the Rising Cost of Insulin* (Apr. 10, 2019), https://www.congress.gov/116/meeting/house/109299/documents/HHRG-116-IF02-Transcript-20190410.pdf.

[88] *Id.*

532. OptumRx's website states that the services Optum provides help improve health outcomes for patients while making prescription drugs more affordable for plan sponsors and individuals, and more sustainable for the country. It further states that OptumRx negotiates better prices with drug manufacturers for our customers and consumers.

533. 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 . . . in 2018, we are doing even more to help keep drugs affordable with our new Savings Patients Money initiative." (emphasis added). [89]

534. The PCMA website states, "PBMs are creating innovative programs that limit consumer out of pocket insulin costs to promote affordable access, as well as clinical programs that improve care and patient outcomes."[90]

535. On March 12, 2019, OptumRx represented, "OptumRx is uniquely able to deploy the broadest range of tools to rein in high drug prices, [which] demonstrates our commitment to delivering better prices for consumers."[91]

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[89] *2017 Drug Trend Report*, CVS HEALTH, (April 5, 2018). https://web.archive.org/web/20200919195000/https://payorsolutions.cvshealth.com/insights/2017-drug-trend-report.

[90] PCMA, *PBMs Reduce Insulin Costs* (last accessed Dec. 18, 2025), https://web.archive.org/web/20201024225737/https://www.pcmanet.org/insulin-managing-costs-with-increasing-manufacturer-prices/.

[91] UnitedHealth Group, *Successful Prescription Drug Discount Program Expands to Benefit More Consumers at Point-of-sale* (Mar. 12, 2019), https://www.unitedhealthgroup.com/newsroom/2019/2019-03-12-prescription-drug-program-expands-to-benefit-consumers-point-of-sale.html.

536. In 2024, Travis Tate, VP of Formulary and Trend Solutions for CVS Caremark represented on CVS Health's website that CVS Caremark's "formulary design continues to deliver savings while optimizing plan member experience."[92]

537. Mr. Tate further represented that CVS Caremark's managed formularies deliver $4.8 billion in client savings and $138 in savings per patient. Mr. Tate also represented that "[CVS Caremark is] dedicated to keeping member costs low so they can afford their medications while limiting member disruption."[93]

538. In April 2024, David Joyner, the Executive Vice President of CVS Caremark, made the following representations in a Fortune article:

a. "[CVS Caremark] exist[s] to make prescription drugs more affordable."

b. "As we work to bring down costs, you'll hear from others who want to raise [drug prices], specifically pharmaceutical companies who are directly responsible for how drugs are priced in our country."

c. "At CVS Caremark, we are creating a more transparent environment for drug pricing in this country . . . for every drug from every manufacturer for every condition and every patient."

d. "[CVS Caremark's] size and scale allow us to go toe-to-toe with drug companies, driving competition and negotiating discounts

[92] Travis Tate, PharmD, Vice President of Formulary and Trend Solutions, *2024 CVS Caremark Formulary Updates*, CVS CAREMARK (2023), https://web.archive.org/web/20240226172223/https://business.caremark.com/insights/2023/2024-cvs-caremark-formulary-updates.html.

[93] *Id.*

that make the difference between someone affording their medication or going without."

e. "[CVS Caremark] take[s] on every challenge, manage every drug, and deliver savings and safety."[94]

539. CVS Caremark's website represents it is "[w]orking to keep prescription drug costs down for members and clients." CVS Caremark further claims it is "[i]mproving health through affordability" because "people are more likely to take their prescribed medications when they know they can afford them – and that can lead to better health outcomes."[95]

540. CVS Caremark also represents to diabetics on the CVS Health website:

a. "Pharmaceutical manufacturers insist that increasing drug prices are a result of them having to pay rebates. This is simply not true."

b. "Pharmaceutical manufacturers also argue that PBMs retain the rebates they negotiate, and that higher prices mean more rebates and greater profits for PBMs. This is entirely false. Rebate retention also has no correlation to higher drug prices."

c. "At CVS Health, we are committed to using every tool possible and continuing to drive innovation to bring down the cost of drugs. We

[94] David Joyner, *It's time for facts in the PBM debate*, FORTUNE (Apr. 3, 2024), https://fortune.com/2024/04/03/time-for-facts-in-the-pbm-debate/.

[95] Joshua Fredell, Vice President & Head of PBM & Specialty Product Innovation, *Keeping medications affordable for members*, CVS CAREMARK (2023), https://web.archive.org/web/20240226164112/https://business.caremark.com/insights/2023/keeping-medications-affordable-members.html.

remain focused on providing the right drug to the right patient at the right time at the lowest possible cost."[96]

541. Express Scripts claimed in a 2019 article titled "What's a Pharmacy Benefit Manager" that Express Scripts "work[s] with plan sponsors to provide a benefit that delivers the best clinical outcome and the lowest possible cost."[97]

542. Express Scripts also publicly represented in this article:

a. "By delivering smarter solutions to patients and clients, PBMs provide better care and lower cost with every prescription, every time."

b. "Rebates do not raise drug prices, drug makers raise drug prices, and they alone can lower them . . . Without PBMs, and specifically without Express Scripts, plan sponsors would have paid exponentially more for their prescription drugs."

c. "We . . . negotiate with drug manufacturers so no one pays more than they need to."

d. "FACT: Public disclosure of negotiated rebates will not lower prescription drug costs. #PBMs Express Scripts negotiates with

[96] *Current and New Approaches to Making Drugs More Affordable*, CVS HEALTH (Aug. 2018), https://web.archive.org/web/20230512045200/https://www.cvshealth.com/content/dam/enterprise/cvs-enterprise/pdfs/ingestion/cvs-health-current-and-new-approaches-to-making-drugs-more-affordable.pdf.

[97] Paul Reyes, *What's a Pharmacy Benefit Manager*, EXPRESS SCRIPTS (Aug. 1, 2019), https://web.archive.org/web/20211009133403/https://www.express-scripts.com/corporate/articles/whats-pharmacy-benefit-manager.

drug manufacturers to increase competition and lower costs for patients."[98]

543. Not only have PBM Defendants intentionally misrepresented that they use their market power to save diabetics money; they have specifically, knowingly, and falsely disavowed that their conduct drives the artificially-inflated list prices higher.

544. On an Express Scripts' earnings call in February 2017, CEO Tim Wentworth stated, "Drugmakers set prices, and we exist to bring those prices down."[99]

545. 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."[100]

546. In 2017, Express Scripts' Wentworth went on CBS News to again argue that PBMs play no role in rising drug prices, stating that PBMs work to "negotiate with drug companies to get the prices down."[101]

547. During the April 2019 Congressional hearings, when asked if PBM-negotiated rebates and discounts were causing the insulin price to increase,

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[98] *Id.*

[99] Samantha Liss, *Express Scripts CEO address drug pricing 'misinformation'*, ST. LOUIS POST-DISPATCH (Feb. 17, 2017), https://www.stltoday.com/business/local/express-scripts-ceo-addresses-drug-pricing-misinformation/article_8c65cf2a-96ef-5575-8b5c-95601ac51840.html.

[100] Lynn R. Webster, *Who is to blame for skyrocketing drug prices?*, THE HILL (Jul. 27, 2017), https://thehill.com/blogs/pundits-blog/healthcare/344115-who-is-to-blame-for-skyrocketing-drug-prices.

[101] *Express Scripts CEO Tim Wentworth defends role of PBMs in drug prices*, CBS NEWS (Feb. 7, 2017), https://www.cbsnews.com/news/express-scripts-tim-wentworth-pbm-rising-drug-prices-mylan-epipen-heather-bresh/.

OptumRx's Chief Medical Officer answered, "we can't see a correlation when rebates raise list prices."[102]

548. In 2019, when testifying under oath before Congress on the rising price of insulins, Senior Vice President Amy Bricker of Express Scripts testified, "I have no idea why the prices [for insulin] are so high, none of it is the fault of rebates."[103]

549. Throughout the relevant time period, PBM Defendants have also misrepresented that they are transparent about the Manufacturer Payments that they receive and that they pass along (or do not pass along) to payors. As stated above, PBM Defendants retain many times more in total Manufacturer Payments than the traditional formulary "rebates" they may pass through—in whole or part—to payors.

550. Despite this, in 2011, OptumRx's President stated: "We want our clients to fully understand our pricing structure . . . [e]veryday 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."[104]

551. In a 2017 CBS News interview, Express Scripts' CEO, represented, among other things, that Express Scripts was "absolutely transparent" about the

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[102] House Energy and Commerce Subcommittee on Oversight and Investigations, House Committee Hearing: *Priced Out of a Lifesaving Drug: Getting Answers on the Rising Cost of Insulin* (Apr. 10, 2019), https://www.congress.gov/event/116th-congress/house-event/109299.

[103] *Id.*

[104] Press Release: *Prescription Solutions by OptumRx Receives 4th Consecutive TIPPS Certification for Pharmacy Benefits Transparency Standards*, UNITEDHEALTH GROUP (Sep. 13, 2011), https://web.archive.org/web/20210501100626/https://www.unitedhealthgroup.com/newsroom/2011/0913tipps.html.

Manufacturer Payments it receives and that payors, "know exactly how the dollars flow" with respect to these Manufacturer Payments.[105]

552. When testifying before Congress in April 2019, Amy Bricker, President of Express Scripts, had the following exchange with Representative John Sarbanes of Maryland regarding the transparency (and lack thereof) of the Manufacturer Payments:

> 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. . . [However] the reason I'm able to get the discounts that I can from the manufacturer is because it's confidential [to the public].
>
> Mr. Sarbanes. What about if we made it completely transparent? Who would be for that?
>
> Ms. Bricker. Absolutely not . . . it will hurt the consumer.
>
> Mr. Sarbanes. I don't buy it.
>
> Ms. Bricker – prices will be held high.
>
> Mr. Sarbanes. I am not buying it. I think a system has been built that allows for gaming to go on and you have all got your talking points. Ms. Tregoning [of Sanofi], you have said you want to guarantee patient access and affordability at least ten times, which is great, but there is a collaboration going on here . . . the system is working for both of you at the expense of the patient. Now I reserve most of my frustration for the moment in this setting for the PBMs, because I think the lack of transparency is allowing for a lot of manipulation. I think the rebate system is totally screwed up, that without transparency there is opportunity for a lot of hocus-pocus to go on with the rebates. Because the list price ends up being unreal in certain ways except to the extent that it leaves certain patients holding the bag, then the rebate is

[105] *Express Scripts CEO Tim Wentworth defends role of PBMs in drug prices*, CBS NEWS (Feb. 7, 2017), https://www.cbsnews.com/news/express-scripts-tim-wentworth-pbm-rising-drug-prices-mylan-epipen-heather-bresh/.

> negotiated, but we don't know exactly what happens when the rebate is exchanged in terms of who ultimately benefits from that. And I think we need more transparency and I do not buy the argument that the patient is going to be worse off, the consumer is going to be worse off if we have absolute transparency . . . *I know when you started out, I understand what the mission was originally with the PBMs . . . But now things have gotten out of control. You are too big and the lack of transparency allows you to manipulate the system at the expense of the patients.* So I don't buy the argument that the patient and consumer is going to get hurt if we have absolute transparency. (Emphasis added)[106]

553. Throughout the relevant time period, the PBMs have made the foregoing misrepresentations consistently and directly to Virginia diabetics through member communications; formulary change notifications; and through extensive direct-to-consumer efforts engaged in with the Manufacturers.

554. PBM Defendants also make these same representations directly to their payor clients—that their interests are aligned with their payor clients, that they lower the price of the at-issue drugs, and that their formulary construction is for the benefit of diabetics and payors.

555. The above stated PBM Defendants' representations are false.

556. Contrary to their representations that they lower the price of the at-issue drugs for diabetics, the PBMs' formulary construction and the Manufacturer Payments they receive in exchange for formulary placement have caused the price paid by diabetics and payors to significantly increase.

[106] House Energy and Commerce Subcommittee on Oversight and Investigations, House Committee Hearing: *Priced Out of a Lifesaving Drug: Getting Answers on the Rising Cost of Insulin* (Apr. 10, 2019), https://www.congress.gov/event/116th-congress/house-event/109299.

557. For example, diabetics in Europe and Canada pay significantly less for their diabetes medications than diabetics in the United States who are affected by the Insulin Pricing Scheme.

558. In addition, diabetics that receive their medications from federal programs that do not utilize PBMs also pay significantly less. For example, in December 2020, the United States House of Representatives Committee on Oversight and Reform issued a Drug Pricing Investigation Report that found that federal health care programs that negotiate directly with the Manufacturers (such as the Department of Veterans Affairs), and thus are outside the PBM Defendants' scheme, paid $16.7 billion less from 2011 through 2017 for certain of the at-issue drugs than what was paid by the Medicare Part D program which relies on the PBM Defendants to set their at-issue drug prices (and thus are victims of the PBMs' concerted efforts to drive up the list prices).

559. As the NYT PBM Investigation concluded:

> The job of the P.B.M.s is to reduce drug costs. Instead, they frequently do the opposite. They steer patients toward pricier drugs, charge steep markups on what would otherwise be inexpensive medicines and extract billions of dollars in hidden fees. . . . [107]

560. The NYT PBM Investigation determined that "the largest PBMs often act in their own financial interest, at the expense of their clients and patients." Specifically, it found:

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[107] Rebecca Robbins and Reed Abelson, T*he Opaque Industry Secretly Inflating Prices for Prescription Drugs*, NEW YORK TIMES (Jun. 21, 2024), https://www.nytimes.com/2024/06/21/business/prescription-drug-costs-pbm.html.

a. PBMs sometimes push patients toward drugs with higher out-of-pocket costs, shunning cheaper alternatives.

b. They often charge employers . . . multiple times the wholesale price of a drug, keeping most of the difference for themselves. That overcharging goes far beyond the markups that pharmacies, like other retailers, typically tack on when they sell products.

c. The largest PBMs recently established subsidiaries that harvest billions of dollars in fees from drug companies, money that flows straight to their bottom line and does nothing to reduce health care costs.

561. Contrary to their representations that they work to promote the health of diabetics, the Insulin Pricing Scheme has priced many diabetics out of these life-sustaining medications. As a result, many of these diabetics are forced to either ration their insulin or skip doses. This behavior is dangerous to a diabetic's health and can lead to a variety of complications and even death.

562. Both PBM and Manufacturer Defendants knew that these representations were false when they made them and affirmatively withheld the truth regarding the artificially-inflated list prices; formulary construction; and Manufacturer Payments from the Virginia diabetics. Both PBM Defendants and Manufacturer Defendants intended to deceive Virginia consumers with diabetes with their misrepresentations.

563. Defendants concealed the falsity of these representations by closely guarding their pricing structures, agreements, and sales figures.

564. Manufacturer Defendants do not disclose to diabetics, payors or the public the actual prices they receive for the at-issue drugs or the amount in Manufacturer Payments they pay to the PBM Defendants.

565. PBM Defendants do not disclose to diabetics, payors or the public the details of their agreements with Manufacturer Defendants or the Manufacturer Payments they receive from them—nor do they disclose the details related to their agreements with payors and pharmacies.

566. Each Defendant also conceals its unlawful deceptive conduct by signing confidentiality agreements with any entity in the supply chain with whom it contracts.

567. PBM Defendants have gone as far as suing governmental entities to block the release of details on their pricing agreements with Manufacturers and pharmacies.

568. Even when audited by payors, PBM Defendants often still refuse to disclose their agreements with Manufacturers and pharmacies, relying on overly broad confidentiality agreements, claims of trade secrets and other unnecessary restrictions.

569. Each Defendant's effort to conceal its pricing structures for the at-issue drugs is evidence that each Defendant knows its conduct is unlawful and deceptive.

570. To make matters worse, Virginia diabetics have no choice but to pay based on Defendants' artificially-inflated list prices because they need these

medications to survive. The Manufacturer Defendants—as well as one additional insulin manufacturer—make virtually all of the diabetes medications available in Virginia, and the PBM Defendants completely dominate the pharmacy benefit services market and control nearly every Manufacturer Payment paid in the market.

571. In sum, the insulin pricing structure created by the Defendants—from the artificially-inflated prices; to the Defendants' misrepresentations related to the reason behind the price; to the inclusion of the artificially-inflated 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 unlawful and deceptive.

572. Virginia diabetics pay for the at-issue diabetes medications at the artificially-inflated prices generated by the Insulin Pricing Scheme because they believed these prices as reasonable bases for their life-sustaining medications.

573. Virginia diabetics did not know, because the Defendants affirmatively concealed, that (a) the list prices were artificially inflated; (b) the list prices were manipulated to satisfy Defendants' profit demands; (c) the list prices bore no relationship to the net prices paid for the at-issue drugs to the Manufacturers; and (d) that the entire insulin pricing structure Defendants created was deceptive.

H. The Insulin Pricing Scheme Has Harmed Diabetics

574. Defendants' formulary exclusions and the rising prices for the at-issue drugs has had a devastating effect on the health of diabetics.

575. As a direct result of the Insulin Pricing Scheme, many Virginia diabetics can no longer afford their diabetes medication and are forced to ration and skip doses.

576. Whether insured or not, most Virginia diabetics pay for their diabetic drug costs based on Defendants' artificially-inflated list prices generated by the Insulin Pricing Scheme and thus the Insulin Pricing Scheme has directly harmed Virginia diabetics.

577. The Insulin Pricing Scheme has caused the prices that Virginia diabetics must pay for insulin and other diabetic drugs to substantially increase over approximately the last fifteen years.

578. The Manufacturer Defendants' list price increases have resulted in high costs for both insured patients and uninsured. In 2019, the Department of Health and Human Services found that for patients using diabetes medications with commercial insurance, 19% of insulin prescriptions required out-of-pocket costs exceeding $70. For uninsured patients, 27% of insulin prescriptions involved costs greater than $70.[108]

579. In addition to financial losses, for many diabetics in Virginia, the Insulin Pricing Scheme has cost them their health and emotional well-being. As a result of increased prices, and the fact that the PBM Defendants have been excluding more affordable diabetes medications from their formularies, many Virginia diabetics have been priced out of these life-sustaining medications.

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[108] HHS Press Office, *New HHS Report Finds Major Savings for Americans Who Use Insulin Thanks to President Biden's Inflation Reduction Act*, U.S. DEPT. OF HEALTH & HUMAN SERVICES (Jan. 24, 2023), https://www.hhs.gov/about/news/2023/01/24/new-hhs-report-finds-major-savings-americans-who-use-insulin-thanks-president-bidens-inflation-reduction-act.html.

580. Unable to afford Defendants' price increases, many diabetics in Virginia have begun to engage in highly risky behaviors with respect to their disease such as rationing their insulin; skipping their refills; injecting expired insulin; reusing needles; and avoiding doctors' visits. To compensate for their lack of insulin, some patients starve themselves, foregoing one or even two meals a day.

581. These practices—which ineffectively control blood sugar levels—can lead to serious complications such as kidney disease and failure, heart disease and heart attacks, infection, amputation, and blindness.

582. A recent study by Yale researchers found that 14% of diabetics face "catastrophic" spending on insulin (defined as 40% of their income beyond what they spend on food and housing) and nearly half of diabetics reported rationing their insulin supply because of its cost.[109]

583. In addition, recent articles have also described GLP-1s as a gamechanger for people living with diabetes. They have been priced out of the reach of tens of millions of people, however, because of the Insulin Pricing Scheme.

584. A recent article by the Kaiser Family Foundation explained how the inflated prices for GLP-1 drugs caused by the Insulin Pricing Scheme is harming diabetics:

> [Over half] of adults who had taken a GLP-1 drug, including those with insurance, said the cost was "difficult" to afford. But it is patients with the lowest disposable incomes who are being hit the hardest. These are people with few resources who struggle to see doctors and buy healthy foods. In the United States, Novo Nordisk

[109] Mallory Locklear, *Insulin is an extreme financial burden for over 14% of Americans who use it,* YALENEWS (Jul. 5, 2022), https://news.yale.edu/2022/07/05/insulin-extreme-financial-burden-over-14-americans-who-use-it.

> charges about $1,000 for a month's supply of Ozempic . . . The high prices also mean that not everyone who needs the drugs can get them. "They're kind of disadvantaged in multiple ways already and this is just one more way," said Wedad Rahman, an endocrinologist with Piedmont Healthcare in Conyers, Georgia . . . By the time many of Rahman's patients see her, their diabetes has gone unmanaged for years [because they cannot afford their medicines] and they're suffering from severe complications like foot wounds or blindness. "And that's the end of the road," Rahman said. "I have to pick something else that's more affordable and isn't as good for them."[110]

585. Even when diabetics can still afford their diabetic medications, as a direct result of PBM Defendants shifting which diabetes medications are favored on their formularies ("non-medical switching"), diabetics are often forced to switch medications every few years or go through a lengthy appeal process (or try the favored drug first) before receiving the patient's preferred medication.

586. Non-medical switching for biologic drugs, such as the at-issue drugs, causes increased health problems for diabetics and increased healthcare costs for diabetics.

587. The Insulin Pricing Scheme has pushed, and will continue to push, access to these lifesaving drugs out of reach for many diabetes patients in Virginia.

588. Because Virginia diabetics continue to pay for the at-issue drugs based on the artificially-inflated prices generated by the Insulin Pricing Scheme, the harm is ongoing.

[110] Renuka Rayasam, *High Price of Ozempic, other diabetes drugs deprive low-income people of effective treatment*, KFF HEALTH NEWS (May 21, 2024), https://kffhealthnews.org/news/article/high-prices-ozempic-mounjaro-wegovy-glp1s/.

I. Defendants' Recent Efforts in Response to Rising Insulin Prices

589. In reaction to the mounting public pressure, Defendants recently have taken action in the insulin marketplace.

590. Defendants have recently begun introducing programs ostensibly aimed at lowering the cost of insulins.

591. These affordability measures fail to address the structural issues that have given rise to the price hikes. Rather, these steps are public relations efforts that do not solve the problem.

592. In addition, in 2023 the Manufacturer Defendants significantly lowered the list prices of certain insulins (in some cases by as much as 70%). While the Manufacturer Defendants each made public statements that the price reductions were designed to help diabetics by making insulin affordable, those statements obscure the true motivations behind these price cuts.

593. First, these price reductions reveal that the Manufacturer Defendants could have taken these steps years ago. The extent of the reductions confirms each Defendants active participation in the Insulin Pricing Scheme and how artificially inflated their prices have been for years.

594. Second, even with the price cuts, the Manufacturer Defendants are still making sizeable profits, and the price is still significantly inflated compared to other countries and competitive pricing systems in the United States that are outside of the Insulin Pricing Scheme (such as the Department of Veteran Affairs).

595. Third, despite years of growing recognition of harm to patients from high diabetic drug pricing, the Manufacturer Defendants did not actually lower their prices of certain insulins until regulatory change forced the price cuts.

596. As explained in the FTC Complaint:

> The American Rescue Plan of 2021 repealed the Average Manufacturer Price (AMP) Cap. Under Medicaid regulations, manufacturers must pay Medicaid rebates equal to the difference between the current average price of the drug paid by retail pharmacies and wholesalers and the inflation-adjusted list price of the drug (sometimes referred to as the Medicaid inflation penalty). If a drug's list price has increased faster than inflation, the manufacturer has to rebate the difference to Medicaid. The AMP Cap, in place since 2010, had capped the Medicaid rebate at 100% of the drug's average price, even if manufacturers continued to raise list prices. The repeal of the AMP Cap, however, took away this 100% rebate maximum. Thus, beginning in 2024, insulin manufacturers who had dramatically increased list prices (exceeding the inflation rate) would be required to pay a Medicaid rebate in excess of 100% of the drug's price on every unit dispensed in Medicaid.
>
> Novolog, and Lantus, which had experienced up to sevenfold list price increases, were among [the drugs affected by the change in the law]. The insulin manufacturers projected incurring hundreds of millions of dollars in Medicaid liability due to the AMP Cap repeal. Because of the relationship between the AMP Cap and list price, however, manufacturers could mitigate the effect of the AMP Cap repeal by lowering list price.[111]

597. Indeed, as a result of the new Medicaid regulations, each of the Manufacturer Defendants faced huge penalties due to their steep insulin price increases if they did not significantly lower their prices by the end of 2023.

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[111] Complaint, *In the Matter of Caremark Rx, LLC, et al,* No. 9437 (FTC), https://www.ftc.gov/system/files/ftc_gov/pdf/d9437_caremark_rx_zinc_health_services_et_al_part_3_complaint_public_redacted.pdf.

598. Finally, the price cuts only affect certain analog insulins and not all diabetes medications. More importantly, the price cuts do not address the fundamental unlawful and deceptive conduct driving the Insulin Pricing Scheme.

V. CLAIM FOR RELIEF

FIRST CAUSE OF ACTION

Virginia Consumer Protection Act, Va. Code §§ 59.1-196, et seq., (Against All Defendants)

599. The Commonwealth re-alleges and incorporates herein by reference each of the allegations contained in the preceding paragraphs.

600. Pursuant to Virginia Code § 59.1-197, the VCPA is to be applied as remedial legislation to promote fair and ethical standards of dealing.

601. During all relevant times, Defendants are or were "persons" and "suppliers," as those terms are defined in Virginia Code § 59.1-198 of the VCPA.

602. Defendants have engaged in "consumer transactions" (including the manufacturing, promoting, reimbursing, offering for sale, and selling of diabetic drugs and providing pharmacy benefit and pharmacy services) as that term is defined in Virginia Code § 59.1-198 of the VCPA.

603. In connection with consumer transactions, the VCPA prohibits suppliers from:

a. Misrepresenting that goods or services have certain quantities, characteristics, ingredients, uses, or benefits pursuant to Virginia Code § 59.1-200(A)(5);

b. Making false or misleading statements of fact concerning the reasons for, existence of, or amounts of price reductions pursuant to Virginia Code § 59.1-200(A)(9); and

c. Using any other deception, fraud, false pretense, false promise, or misrepresentation in connection with a consumer transaction pursuant to Virginia Code § 59.1-200(A)(14).

604. Defendants violated Virginia Code § 59.1-200(A)(5), (9), and (14) through the acts and practices described in this Complaint.

605. In particular, Defendants misrepresented that goods or services have certain characteristics or benefits, in violation of Virginia Code § 59.1-200(A)(5), in the following way:

a. In furtherance of the Insulin Pricing Scheme, at least once a year for each year during the relevant time period, the Manufacturer Defendants reported and published artificially-inflated list prices to compendia, pharmacies, PBMs, and distributors. In doing so, the Manufacturers held these prices out to be reasonably related to the actual net prices realized by the Defendants and to be prices that arose from competitive and transparent market factors.

b. The Manufacturer Defendants' list prices were and are so untethered from the actual, net price realized by Defendants, as well as from the cost to manufacture, market, and sell the at-issue drugs, as to constitute a deceptive price.

c. At no point did Defendants disclose that the prices associated with the at-issue drugs were generated by the Insulin Pricing Scheme.

d. Further, the Manufacturer Defendants misrepresented that their price increases for the at-issue drugs were driven by research and development and benefited diabetics and concealed the true reasons for the increases.

e. In reality, the Manufacturer Defendants raised their list prices (and corresponding Manufacturer Payments) solely for the purpose of increasing their and the PBMs' profits at the expense of diabetics.

f. Despite knowing these prices were false and artificially inflated, PBM Defendants ensured that the Manufacturers' list prices harmed diabetics by requiring that their contracts with both pharmacies and with payors include such prices as the basis for payment.

g. By granting the at-issue diabetes medications with the highest list prices preferred formulary positions, PBM Defendants ensured that prices generated by the Insulin Pricing Scheme would harm diabetics and the Commonwealth.

606. PBM Defendants further misrepresented that goods or services have certain characteristics or benefits, in violation of Virginia Code § 59.1-200(A)(5) by:

a. Misrepresenting that their formulary construction lowers the cost of prescription drugs and promotes patient health;

b. Misrepresenting that the Manufacturer Payments they pay and receive lower the cost of prescription drugs;

c. Misrepresenting that their formulary decisions are evidence- and/or value-based decisions;

d. Misrepresenting that their relationships with their affiliated pharmacies, including CVS Pharmacy and their captive mail order pharmacies, lowers the cost of prescription drugs and promotes patient health;

e. Misrepresenting and concealing the reasons behind the price increases for prescription drugs;

f. Misrepresenting that their formulary preferences and exclusions are lowering prices and promoting patient health;

g. Misrepresenting the amount of "savings" that they generate for their clients, patients, and the healthcare system;

h. Failing to disclose and concealing that the Manufacturer Payments that they pay and receive are intended to and do exclude lower priced drugs from formularies and drive up their profits;

i. Failing to disclose that they are utilizing rebate aggregators, including Ascent Health, Emisar Health, and Zinc Health, to rename, obfuscate, and retain Manufacturer Payments;

j. Failing to disclose and concealing that they financially benefit from preferring and/or excluding certain prescription drugs on their formularies; and

k. Failing to disclose and concealing that formulary preferences and exclusions are not based on the best interests of their clients and/or diabetics.

607. Defendants made false or misleading statements of fact concerning the reasons for, existence of, or amounts of price reductions in violation of Virginia Code § 59.1-200(A)(9), in the following ways:

a. Defendants utilized the artificially-inflated price—which Defendants are directly responsible for inflating and which Defendants know is untethered from the actual price—to make false and/or misleading statements regarding the amount of savings that Defendants generate for Virginia diabetics.

b. In making these representations, Defendants fail to disclose that the amount of "savings" they have generated is calculated based on the artificially-inflated list price, which is not paid by any entity in the pharmaceutical pricing chain, and which Defendants are directly responsible for artificially inflating.

c. Defendants also misrepresented to Virginia diabetics that the Manufacturer Payments they received and paid lowered the actual price of the at-issue drugs.

d. Defendants continue to make these misrepresentations and publish prices generated by the Insulin Pricing Scheme, and diabetics continue to purchase diabetes medications at Defendants' prices, as a result of the ongoing Insulin Pricing Scheme.

608. By engaging in the Insulin Pricing Scheme, as described herein, all Defendants used deception, fraud, false pretenses, false promises, and misrepresentations, in violation of Virginia Code § 59.1-200(A)(14).

609. Defendants made these misrepresentations with the intent to deceive Virginia diabetics.

610. Defendants' representations are false, and at all relevant times Defendants knew they were false.

611. At all times relevant hereto, Defendants affirmatively withheld the truth from diabetics in the Commonwealth.

612. Defendants acted willfully in violation of the VCPA.

613. Individual consumers have suffered losses as a result of these violations of the VCPA by Defendants.

614. Each at-issue transaction, act, and misrepresentation in furtherance of the Insulin Pricing Scheme constitutes a separate violation of the VCPA.

VI. PRAYER FOR RELIEF

WHEREFORE, Plaintiff, the Commonwealth of Virginia, prays that this Court:

A. Temporarily and permanently enjoin the Defendants and their officers, employees, agents, successors, and assigns from violating § 59.1-200 of the VCPA pursuant to Virginia Code § 59.1-203;

B. Grant judgment against Defendants, jointly and severally, and award to the Commonwealth all sums necessary to restore to any consumers the money or property acquired from them by Defendants in connection with violations of § 59.1-200 of the VCPA pursuant to Virginia Code § 59.1-205;

C. Enter any additional orders or decrees as may be necessary to restore to any consumers the money or property acquired from them by Defendants in connection with violations of § 59.1-200 of the VCPA pursuant to Virginia Code § 59.1-205;

D. Grant judgment against the Defendants, jointly and severally, and award to the Commonwealth maximum civil penalties per violation for each willful violation of § 59.1-200 of the VCPA pursuant to Virginia Code § 59.1-206(A), the exact number of such violations to be proven at trial;

E. Grant judgment against the Defendants, jointly and severally, and award to the Commonwealth its costs, reasonable expenses incurred in investigating and preparing the case up to $1,000.00 per violation of

§ 59.1-200 of the VCPA, and attorney's fees pursuant to Virginia Code § 59.1-206(D); and

F. Award restitution, disgorgement, penalties and all other legal and equitable monetary remedies available under the VCPA and the general equitable powers of this Court in an amount according to proof;

G. Award 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 Complaint; and

H. Award such other, further and different relief as the case may require and the Court may deem just and proper under the circumstances.

Respectfully submitted,

JASON S. MIYARES
Attorney General of Virginia

Steven G. Popps
Chief Deputy Attorney General

Thomas J. Sanford (VSB No. 95965)
Deputy Attorney General
Civil Litigation Division

Richard S. Schweiker, Jr. (VSB No. 34258)
Chief and Senior Assistant Attorney General

Joelle E. Gotwals (VSB No. 76779)
Senior Assistant Attorney General

Office of the Attorney General of Virginia
202 North 9th Street Richmond, Virginia 23219
Telephone: (804) 786-8789
Facsimile: (804) 786-0122
tsanford@oag.state.va.us
rschweiker@oag.state.va.us
jgotwals@oag.state.va.us

COMMONWEALTH OF VIRGINIA, *EX REL.* JASON S. MIYARES, ATTORNEY GENERAL

By: */s/ R. Johan Conrod*
R. Johan Conrod (VSB No. 96765)
Joanne M. Cicala*
Josh Wackerly*
R. Johan Conrod (VSB No. 96765)
Cicala Wackerly Conrod PLLC
101 College Street
Dripping Springs, TX 78620
Tel: (512) 275-6550
joanne.cicala@cwc.law
josh.wackerly@cwc.law
johan.conrod@cwc.law

* *Pro hac vice* applications forthcoming