STATEMENT

PhRMA
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In Opposition to Senate Bill 2384 (DiPalma)
March 26, 2026

Position: PhRMA respectfully opposes Senate Bill 2384 (SB 2384). PhRMA believes that discussions about the affordability of medicines are important, but the intention of this bill is for the government to set drug prices, which could limit the prescription options available to Rhode Island. SB 2384 shortsightedly targets drug spending in ways that likely will have long-term, harmful effects on innovation and the development of new, life-saving therapies.

PhRMA opposes price setting, including referencing the Medicare Maximum Fair Price.

SB 2384 automatically imposes a price control for certain medicines in Rhode Island based on the Medicare "maximum fair price" (MFP). The Medicare MFP is a price-setting mechanism recently enacted as part of the federal Inflation Reduction Act (IRA). Regulating drug prices in-state could lead to a shortage of or limit access to medicines for patients. Specifically, if a pharmacy or provider cannot obtain a medicine at the MFP, the medicine may not be available to Rhode Island residents.

States likely will have trouble broadening MFP to non-Medicare markets given the MFP was designed specifically for the Medicare program, which has a patient population that differs greatly from the markets to which this "upper payment limit" (UPL) would apply. At the federal level, even CMS's complicated process has outstanding key issues not yet resolved, and the MFP applies only to Medicare, raising serious doubts about how price controls will be effectuated on a state-by-state basis as applied to all purchases and reimbursements. The critical question—how to effectuate a UPL for a single state when the U.S. pharmaceutical market, pricing, and distribution strategies are national—also remains unanswered and has been all but ignored by this bill. This is a significant shortcoming that Rhode Island cannot disregard, because an unworkable approach could lead to access challenges for patients. If a UPL-priced product cannot be purchased or reimbursed in the state at or below the UPL, it is unclear whether the product will be available in the state at all.

Medicare beneficiaries are beginning to be negatively impacted by the creation of MFP at the federal level.

Beginning in 2026, the Medicare Drug Price Negotiation Program (MDPNP) set an MFP in the Medicare program for certain medicines. State proposals like SB 2384 would apply MFP as a price control to non-Medicare markets, which could be problematic for patients' access to medicines. For example, Avalere's analyses of 2025 and 2026 Part D plan formularies found Part D plans were tightening access to branded medicines, changes that could translate into fewer therapeutic alternatives within classes that contain selected drugs.[1,2] Avalere's 2026 Part D plan formulary analysis also found Part D plans increased utilization management for some selected drugs along with slight shifts in tier placement.[3] Also, a 2025 physician survey by Avalere found that nearly all providers (92%) would be somewhat or very likely to stop stocking Part B drugs subject to MFP.[4]

[1] Avalere Health. 2025 Part D Formularies Shift to More Coinsurance and UM. October 2024, available here.
[2] Avalere Health. Part D Formulary Management Tightens in 2026. November 2025, available here.
[3] Avalere Health. Part D Formulary Management Tightens in 2026. November 2025, available here.
[4] Avalere Health. White Paper: Provider Survey on Part B Negotiation. Sept. 2025, available here.

In addition to concern that federal price controls could cause plans and providers to limit patient access to medicines, experts predict that price controls in Medicare will shift incentives for research and development away from many diseases and illnesses, including those that disproportionately affect underserved communities, such as diabetes, heart disease, and some cancers.[5] It is well established that price control policies would have harmful impacts on biopharmaceutical investment and innovation, and American patients would pay the price.[6] In a 2025 analysis, Vital Transformation's research found that aggregate small molecule investments by companies valued at less than $2 billion dropped by 68% since the Inflation Reduction Act was introduced.[7]

This legislation does not account for insurance benefit design issues that prevent discounts from flowing to patients, and SB 2384 assumes incorrectly that the price a patient pays is determined solely by drug manufacturers.

This bill singles out the biopharmaceutical industry and ignores the variety of stakeholders involved in determining what consumers ultimately pay for a medicine, including insurers, pharmacy benefit managers (PBMs), wholesalers, and the government. For example, PBMs and payers that negotiate substantial rebates, discounts, and other price concessions annually dictate the terms of coverage for medicines and the amount a patient ultimately pays. According to research from the Berkeley Research Group (BRG), rebates, discounts, and fees account for an increasing share of spending for brand medicines each year, while the share received by manufacturers has decreased over time[8]. Manufacturers retain only 49.9% of brand medicine spending—the rest goes to others in the supply chain, including insurers/plan sponsors, the government, and PBMs.[9] In fact, 42% of every dollar spent on medicines goes to pharmacy benefit managers (PBMs).[10]

Looking ahead, average net price growth is projected to be -1 to -4% per year through 2028.[11] This, of course, does not necessarily reconcile with what patients are feeling at the pharmacy counter, which is why looking at the whole system is so important. For example, despite manufacturers' rebates and discounts negotiated by health plans, nearly half of commercially insured patients' out-of-pocket spending for brand medicines is based on the medicine's list price rather than the negotiated price that health plans receive.[12]

This legislation ignores that there are meaningful policies for addressing affordability without utilizing government price-setting that could reduce treatment options for patients.

PhRMA is increasingly concerned that the substantial rebates, discounts, and other price concessions paid by pharmaceutical manufacturers, approximately $356 billion in 2024,[13] do not make their way to offsetting patient costs at the pharmacy counter. Patients need concrete reforms that will help lower the price they pay for medicines at the pharmacy, such as sharing negotiated savings on medicines directly with patients, making cost-sharing assistance count toward a plan's out-of-pocket spending requirements, and making monthly costs more predictable. These policies can be accomplished without utilizing price-setting, which can reduce the options available to treat patients.

[5] Kenneth E. Thorpe, Penny Wise and Pound Foolish: IRA Impact on Chronic Disease Costs in Medicare, Health Affairs (June 27, 2024)
[6] *See, e.g.,* Matcha, G. (May 2025). The Global Risks of America's "Most-Favored-Nation" Drug Pricing Policy. *The Petrie-Flom Center.* Available at: https://petrieflom.law.harvard.edu/2025/05/22/the-global-risks-of-americas-most-favored-nation-drug-pricing-policy/.
[7] Vital Transformation, Inflation Reduction Act – Two Years On Investor Behavior, R&D Impacts, & Proposed Solutions. April 2025, Available at: https://vitaltransformation.com/2025/04/inflation-reduction-act-two-years-on-investor-behavior-rd-impacts-proposed-solutions/.
[8] BRG: The Pharmaceutical Supply Chain, 2013–2023. January 2025
[9] *Ibid*.
[10] Percher, Eric. "Trends in Profitability and Compensation of PBMs and PBM Contracting Entities." Nephron Research LLC., Sept. 2023, available here.
[11] IQVIA. "Use of Medicines in the U.S. 2024: Usage and Spending Trends and Outlook to 2027." Published May 2024.
[12] IQVIA Institute for Human Data Science. Medicine spending and affordability in the United States. Published August 2020. Accessed August 2020. https://www.iqvia.com/insights/theiqvia-institute/reports/medicine-spending-and-affordabilityin-the-us.
[13] Fein, A. "The 2025 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers," Drug Channels Institute. March 2025.

Further, imposing price controls like MFP myopically targets prescription drugs without addressing other components of our highly interconnected health care system, such as hospitalizations, preventive care, administration, taxes, and benefit mandates[14].

Price controls on brand medicines raise constitutional concerns.

Application of price controls to patented medicines raises constitutional concerns under the Supremacy Clause because it would restrict the goal of federal patent law, which is to provide pharmaceutical patent holders with the economic value of exclusivity during the life of a patent. Congress determined that this economic reward provides appropriate incentive for invention and Rhode Island is not free to diminish the value of that economic reward. Specifically, in the case of *BIO v. District of Columbia, 496 F.3d 1362 (2007)*, the U.S. Court of Appeals for the Federal Circuit overturned a District of Columbia law imposing price controls on branded drugs, reasoning that the law at issue conflicted with the underlying objectives of the federal patent framework by undercutting a company's ability to set prices for its patented products. The bill also raises constitutional concerns about Rhode Island's ability to regulate commercial activity beyond its own borders. *See Nat'l Pork Producers Council v. Ross*, 143 S. Ct. 1142, 1157 n.1 (2023); *Association for Affordable Medicines v. Frosh*, 887 F.3d 664 (4th Cir. 2018).

This legislation could harm Rhode Island's economy.

On average, it takes more than 10 years and $2.6 billion to research and develop a new medicine. Just 12% of drug candidates that enter clinical testing are approved for use by patients. Efforts to impart price controls on innovative manufacturers could chill the research and development of new medicines by taking away the incentives that allow manufacturers to invent new medicines. Price controls also could severely reduce Rhode Island patients' access to medicines, as is seen abroad.

The biopharmaceutical sector is committed to bringing new treatments and cures to patients. This commitment to innovation supports high-quality jobs and is a vital part of Rhode Island's economy and its economic competitiveness. The biopharmaceutical sector directly accounted for 2,424 jobs in Rhode Island in 2022 and supported another 9,234 jobs for a total of 11,658 jobs.[15] These jobs generate over $253.6 million in state and federal tax revenue. This bill could place these jobs, and tax revenue, in jeopardy.

PhRMA recognizes the access challenges faced by patients in Rhode Island with serious diseases. We stand ready to work with the Rhode Island legislature to develop market-based solutions that help patients better access and afford their medicines at the pharmacy counter. We believe this bill would not help patients better access breakthrough, innovative medicines and respectfully oppose the passage of SB 2384.

We urge you to vote no on SB 2384 for these reasons.

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The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country's leading innovative biopharmaceutical research companies, which are laser focused on developing innovative medicines that transform lives and create a healthier world. Together, we are fighting for solutions to ensure patients can access and afford medicines that prevent, treat and cure disease. Over the last decade, PhRMA member companies have invested more than $850 billion in the search for new treatments and cures, and they support nearly five million jobs in the United States.

[14] Conn. Bioscis. Growth Council Drug Price Controls Are 'Ill-Conceived, Counterproductive', (April 2021. .

[15] TEConomy Partners, LLC. The Economic Impact of the U.S. Biopharmaceutical Industry: 2022 National and State Estimates. February 2024. Prepared for PhRMA.