Scaling the "Rebate Wall": Growing Scrutiny of Rebate Contracting in Pharma and Potential Responses

BY PETER C. HERRICK AND MONSURA A. SIRAJEE

FROM THE PRESIDENT, CONGRESS, STATE attorneys general, and regulators like the Federal Trade Commission and the Department of Health and Human Services, to social and news media and consumers, we often hear the refrain that prescription drug costs are too high. Yet, despite this seemingly widely held view, solutions to rising drug costs have vexed policymakers and regulators for decades.

Increasingly in recent years, drug manufacturers, pharmacy benefit managers (PBMs), and health plans alike have turned to rebate contracting as the answer, seeking to use rebates both to reduce prices and induce lower cost drugs to be dispensed at the pharmacy counter. Across the U.S. economy, rebates like these are a mainstay of sales forces encouraging customers to buy more from them while getting more "bang for the buck." So, rebates on prescription drugs are universally viewed as good for consumers and the economy as a whole . . . right?

Not so fast say Congress, regulators, and private plaintiffs who contend that rebating in the prescription drug industry may, somewhat counterintuitively, result in *higher* prices to consumers. Rebate contracting between drug manufacturers and PBMs and health plans—now an unexceptional industry practice—faces ever increasing scrutiny for its impact on drug pricing and out-of-pocket costs to consumers. Congress has taken up several proposed bills targeting rebating practices.[1] The FTC has issued a report to Congress on "rebate walls,"[2] launched an inquiry into PBMs (including the competitive implications of rebating),[3] and issued a policy statement on rebates in pharma contracts.[4] In parallel, the FTC, state attorneys general, and private plaintiffs (often major pharmaceutical firms themselves) have challenged drug rebate contracting practices in court.

But what are the implications of this scrutiny for the pharmaceutical industry and consumers? For pharmaceutical companies, PBMs, practitioners, and other stakeholders, this growing attention on rebating practices raises questions about how to navigate a potential litigation and regulatory minefield while balancing commercial goals and antitrust risk. And policymakers and regulators face real potential for overcorrection and unintended side effects by regulating or challenging widely used commercial practices without clear evidence that they are indeed the culprit behind purportedly high drug costs.

We explore the theory animating "rebate wall" claims, how economists have attempted to analyze and quantify the economic impact of rebates on the industry and consumers, and how courts have dealt with the theory in recent years.

The "Rebate Wall" Theory Explained

In the pharma context, rebates typically arise in contracts between drug manufacturers on the one hand and commercial health plans, PBMs, and Medicaid programs on the other. As in many other industries, drug companies frequently offer rebates (or increased rebates) in exchange for preferred or exclusive positions on a PBM or health plan's formulary (the list of prescription medications covered by a health insurance plan). According to a September 2022 HHS report, rebate contracting has nearly tripled over the last decade as a percentage of total drug spending, going from "11.7 percent in 2012 to a projected 32.5 percent in 2022."[5] This trend shows no signs of slowing.

So why is that a problem? PBMs and drug manufacturers maintain it is not, as rebates can and do lead to lower out-of-pocket costs for patients and reduced net pricing to PBMs and health plans, while allowing drug innovators to compete with lower cost suppliers, such as generics or biosimilars. This, they would argue, ultimately leads to more choice and other benefits for end consumers.[6]

But in recent years, government and private litigants alike have countered—with some limited success—that rebate contracting can spring a "trap" for payors by entrenching incentives that prevent lower cost drugs from being dispensed at the pharmacy counter.[7] Under some contracts, they contend, the loss or reduction of rebates—because a lower cost competing drug is added to the PBM or health plan's formulary or put in a more advantageous tier—can cause a health plan to pay significantly more overall on a net basis despite the presence of a cheaper option on the market. As the FTC puts it, if a PBM or health plan "is unable to switch a sufficient proportion of its covered patients to the lower-priced alternative, then granting a rival drug formulary access is not worth losing the original rebates. . . . This 'rebate wall' may give payers strong incentives to block patient access to lower-priced medicines, whereas absent

Peter C. Herrick is a partner and Monsura A. Sirajee is a counsel at O'Melveny & Myers LLP. While at a previous firm, Peter represented Alvogen in Indivior v. Alvogen.

rebates a lower-priced equally effective product would tend to take sales from the higher priced incumbent product."[8]

If you are scratching your head at that seeming paradox, you are not alone. To illustrate the theory, suppose the manufacturer of an incumbent drug (call it "Alpha") enters into a contract with a PBM under which Alpha's list price of $200 per month is reduced through rebates to a net cost of $25 per month. Alpha's manufacturer wants to ensure that its product will be dispensed in light of this substantial discount, so it requires that the PBM put Alpha in the most advantageous formulary tier and that no other competing drug be allowed on the PBM's formulary. Sounds reasonable, right?

Well, suppose a new, low-cost alternative (call it "Beta") comes on the market at $10 per month. Now the PBM has to do some math—what happens if the PBM puts Beta on its formulary and loses those generous rebates on Alpha? If it does so but a large percentage of patients choose to stay on Alpha (e.g., because they have used it for years), then the PBM may be worse off on a net basis because the increased cost for Alpha could outweigh any savings from promoting Beta.

This math could be further complicated if Alpha's manufacturer offers multiple drugs and conditions its rebates on favorable formulary status across the entire bundle. Imagine a contract where, if the payor falls below a certain amount of purchases or fails to put all of those drugs in an advantageous tier, it could lose rebates on its purchases of all of them. Some, including the FTC, argue this dynamic can prevent a new entrant from obtaining access to a payor's formulary altogether if it does not have a portfolio of drugs or lacks established volume to offset higher prices on the incumbent's other drugs.

Similarly, if Alpha treats multiple indications and the manufacturer makes its rebates contingent on preferred formulary positions across all of them, some argue this can prevent entry of a newly approved product with superior efficacy or a lower price in only one indication.[9]

Attempting to Quantify the Impact of Rebate Contracting

While rebate contracts may be the villain *du jour* in the U.S. drug cost debate, the economic research on drug rebating practices' competitive impact on the healthcare system has been decidedly mixed, making it far from certain that they are doing anything other than reducing net prices paid by PBMs and health plans and illustrating the challenge Congress, regulators, and the courts face in assessing what, if any, action to take to rein them in.

Wayne Winegarden, Senior Fellow and Director of the Center for Medical Economics and Innovation at Pacific Research Institute, contends that rebate walls block competition and impose excessive costs on patients.[10] Winegarden argues that rebate walls inappropriately create restrictions that can delay patient access to appropriate care: "[w]hen the dollar sales of a drug are large enough, which often occurs when a drug treats multiple indications, losing these dollar rebates overwhelms the potential savings that lower-priced competitive drugs can offer insurers and PBMs."[11] He further asserts that restrictions on drug formularies are linked to reduced patient adherence to their prescribed medicines, which is connected to worse patient health outcomes and higher healthcare costs. He cites a study that found that patients whose insurance plans required a "stepped" approach for their treatment—i.e., where specified drugs must be tried before other therapies would be covered by their insurance—were less likely to adhere to their medication compared to those with only "prior authorization" requirements or no restrictions at all. Based on his analysis of patients with employer-sponsored health insurance, patients who are on Medicare, and patients who require drugs that are infused in a clinical setting, he concludes that individual patients could reclaim up to tens of thousands of dollars in potential savings if what he describes as rebate wall practices were eliminated.[12]

Professor Casey Mulligan at the University of Chicago cautions that a regulatory cure may be worse than the disease—if rebates can even be characterized as a problem at all. Mulligan examines the "regulatory risk-reward" and quantifies the potential impact of regulation by examining rebate rules in Medicare Part D, commercial, and insulin settings and the economic impact of contract transparency rules and limits on pharmacy Direct and Indirect Remunerations.[13] His model provides an economic interpretation of so-called rebate walls. Although he finds that rebate regulations would effectively reduce the use of volume discounting by drug manufacturers, he concludes that their implementation could *increase* net brand prices up to a whopping 52 percent and drug-plan premiums up to 31 percent. Contrary to Winegarden, Mulligan also observes that rules on rebates could have the unintended effect of *reducing* drug utilization (including generics) up to 8 percent for insulin and about 1 percent for drugs generally and *slowing* the pace of drug innovation. As he points out, manufacturer volume discounts encourage utilization, all else equal, and discounts to plans and PBMs incentivize them to push better patient drug adherence and use. In contrast, rules governing rebates reduce utilization incentives for those companies.

Moreover, rebate rules would, in his view, discourage competition among drug manufacturers and redistribute benefits to incumbents by inflicting higher costs on patients, plans, and other third parties (e.g., taxpayers and future consumers). And he points out that regulations might discourage new competition among PBMs because larger incumbent PBMs are better able to adapt to them.

In *A Unifying Analytical Framework for Loyalty Rebates*, Professor Fiona Scott Morton at the Yale School of Management and attorney Zachary Abrahamson attempt to construct a framework to assess rebates' competitive impact. They assert that "demand contestability determines the

competitive effects of loyalty rebates."[14] They argue that three contract terms affect the rebate contract's "competitive consequences": (i) the discount; (ii) the threshold to qualify for the rebate or discount; and (iii) the "contestable share"—i.e., the share of the customer base or market that an entrant can "supply in the short run."

With these terms as backdrop, they assert that a number of "conditions" must be met for loyalty discounts to have an exclusionary effect.

- First, they argue that the incumbent must have non-contestable share because it is the "leveraging of non-contestable share that makes loyalty rebates an especially inexpensive method of exclusion."
- Second, in their view, the threshold to qualify for rebates must be above the non-contestable share, otherwise the loyalty rebate does not impair entry and causes no shift in market share.
- And third, they argue that the loyalty rebate "must impose on the disloyal buyer a significant financial penalty" because a rebate with only a trivial financial effect is unlikely to "unreasonably restrain trade."

Notably, they observe a wide variety in rebating programs, which they believe affects how such programs should be assessed—"[r]ebates can be current, retroactive, cover all units, or cover only future units. Consumers can have uniform or heterogeneous valuations and can buy one unit or have downward-sloping demand. The entrant's products can be part of a product line with economies of scope in production or be substitutes for or complements to the incumbent's products."

While economic studies have yet to reach consensus, one conclusion appears clear: one-size-fits-all rules do not account for the wide diversity in rebating practices (as well as the mix of models deployed in the economic literature) or the difficulty in quantifying harm, if any, in this space. Lawmakers and courts should therefore tread carefully and refrain from making blanket policies or rulings that could overcorrect the perceived problem and impede contracting practices that actually benefit consumers by lowering prices, increasing innovation and competition, and spurring utilization.

Court Challenges to "Rebate Walls"

As some "rebate wall" theories have garnered attention from policymakers and regulators, litigants have increasingly brought cases alleging that they violate the antitrust laws, albeit only sparingly using the term "rebate wall" to describe them.[15] These antitrust challenges to drug rebating practices have achieved mixed results, and few have survived past summary judgment, reflecting the challenges plaintiffs face in persuading courts that rebate contracts harm competition.[16] One thread they share: the specific facts of each case matter a great deal, making any attempt to draw universal conclusions about whether pharma rebate contracts harm competition tenuous at best.

***Eisai v. Sanofi* (2016).** The Third Circuit's decision in *Eisai v. Sanofi* exemplifies the uphill battle that a plaintiff can face in challenging contracts that offer rebates on drugs.[17] There, Eisai sued Sanofi for requiring hospitals to buy minimum volumes of Sanofi's anticoagulant drugs to obtain a discount on their total purchases from Sanofi. Sanofi marketed an anticoagulant with at least ten indications, while Eisai marketed a competing anticoagulant with only five indications. As a result, Eisai claimed the additional indications for which its drug was not approved segmented the market between contestable and non-contestable demand. But the court found no competitive harm from Sanofi's contracts because (i) Eisai failed to ground its claims in "concrete examples of anticompetitive consequences in the record"—identifying only "a few dozen hospitals out of almost 6,000" that could not purchase Eisai's product because of Sanofi's conduct and (ii) Sanofi's prices increased at a similar rate as Eisai's. And the court rejected Eisai's theory that Sanofi's rebates "bundl[ed] each customer's contestable demand . . . with the customer's incontestable demand" in part because Eisai failed to "explain what percentage of incontestable demand" for Sanofi's product arose from its unique indications "as opposed to the other factors."

***Pfizer v. Johnson & Johnson* (2018).** In contrast, the *Pfizer v. J&J* court found allegations that rebate contracts were anticompetitive sufficient to survive a motion to dismiss.[18] There, Pfizer claimed that J&J created a rebate "trap" for its drug, Remicade, that prevented Pfizer's biosimilar, Inflectra, from competing despite its "significantly lower price" unit-for-unit. The court took particular note of the timing of J&J's actions—within weeks of the Inflectra launch, J&J allegedly began to deploy a scheme designed to block insurers from reimbursing, and providers from purchasing, Inflectra or other biosimilars. Pfizer alleged that J&J's rebate contracts resulted in Inflectra not appearing on insurers' medical policies or its being designated as a "fail first" product—meaning that it would only be reimbursed if Remicade was first tried but failed to help the patient. Pfizer alleged that these tactics resulted in roughly 90 percent of all providers deciding to forgo Inflectra despite its lower cost. After the court denied J&J's motion to dismiss, the parties reached a confidential settlement in 2021.[19]

***In re: EpiPen* (2022).** Seemingly similar allegations in *In re: EpiPen*, however, failed to survive summary judgment.[20] There, the district court granted Mylan's summary judgment motion on Sanofi's antitrust claims alleging that Mylan's rebates for EpiPens foreclosed Sanofi's competing product, Auvi-Q, from the market. A key fact in the judge's decision: Sanofi initially priced Auvi-Q higher than EpiPen as a "premium" alternative, so customers rationally might have chosen EpiPen as the lower cost option, rather than being blocked from selecting Auvi-Q by Mylan's contracts as Sanofi alleged. The court also found that Mylan's exclusive contracts were relatively short in duration and easily terminable, suggesting that customers could switch to

Auvi-Q if they so desired. And Sanofi also had some success in negotiating exclusive contracts for its own product, further undermining its claim that Mylan's contracts blocked it from entering from the market. The Court of Appeals for the Tenth Circuit affirmed summary judgment in favor of Mylan.[21]

***Indivior v. Alvogen* (2023).** In *Indivior v. Alvogen*, the court denied Indivior's summary judgment motion as to Alvogen's claim that Indivior's rebate contracts blocked it from competing against the blockbuster drug, Suboxone Film.[22] Alvogen alleged that Indivior prevented AB-rated generic versions of Suboxone Film from gaining share by entering into contracts with PBMs and health plans that amounted to a rebate wall: Indivior allegedly structured its rebates in the years leading up to generic launch so that, if payors ever put generic film on their formularies, "they would face a substantial, punitive price increase on branded Suboxone Film." In denying Indivior's motion for summary judgment, the court put substantial weight on Alvogen's economic expert analysis showing that these contracts prevented Alvogen and other generics from gaining share anywhere close to what Indivior's own documents had predicted, despite generics having a lower net price than Indivior's Suboxone Film. The court also rejected Indivior's argument that there could be no foreclosure because Alvogen had secured some payor contracts and gained some share in the market (seemingly in contrast to the weight the *EpiPen* court put on Sanofi's success in negotiating exclusive contracts). Instead, the court cited testimony that as an AB-rated generic, Alvogen ordinarily did not need to pursue contracts with PBMs and health plans, given the typically automatic conversion of the market upon generic launch. The parties settled the case in November 2023.[23]

***Regeneron Pharms, Inc. v. Amgen Inc.* (2023).** More recently, Regeneron alleged that Amgen gave PBMs rebates on other drugs—specifically, its blockbuster drugs Otezla and Enbrel—in return for exclusive or preferred formulary placement for Repatha.[24] Regeneron further alleged that the size of the rebates on Otezla and Enbrel left PBMs with "no viable choice" but to accept Amgen's rebating offer and to exclude Regeneron's Praluent from their formularies. In denying Amgen's motion to dismiss, the court noted that Regeneron had plausibly alleged that, when Amgen's annual bundled rebate is attributed only to sales of Repatha, it results in Repatha being priced below cost. The court did not credit Amgen's argument that the contracts are short term in duration, that at least some agreements with PBMs do not condition rebates on Repatha exclusivity, and that Regeneron itself engages in exclusive arrangements for its competing product Praluent, finding that all of these arguments were fact-intensive and ill-suited for the pleading stage. The court also found that 22 percent market foreclosure was sufficient to state an antitrust claim, at least at the motion to dismiss stage, particularly where the complaint also alleged that Repatha has monopoly power and is "not covered" on the formularies of payors accounting for at least 50% of the total prescriptions in the market. Discovery in the case is ongoing.

***FTC v. Amgen, Inc.* (2023).** Federal and state enforcers have also not shied away from challenging rebating practice.[25] In May 2023, the FTC filed a complaint seeking to block Amgen's acquisition of Horizon Therapeutics, alleging that Amgen's rebate bundling practices would inhibit competition against two key Horizon drugs if the merger were allowed to close.[26] In September 2023, the FTC reached a settlement with Amgen, under which Amgen is prohibited from bundling an Amgen product with those Horizon medications.[27] In addition, Amgen may not condition any product rebate or contract terms related to an Amgen product on the sale or positioning of either of those Horizon drugs and is barred from using any product rebate or contract term to exclude or disadvantage any product that would compete with them.

***Insulin Price-Fixing Litigation* (2023).** State AGs have also begun to pursue rebate wall-style theories in litigation. In August 2023, a Judicial Panel on Multidistrict Litigation consolidated 13 insulin price-fixing lawsuits and tag-along cases from states, counties, and private entities against insulin manufacturers and PBMs, who face claims that they inflated insulin prices, including through rebating practices that allegedly harm competition.[28]

As these cases move forward, they may be a bellwether for further rebate contracting challenges by states and federal regulators.

The Road Ahead

In this evolving enforcement and litigation environment, pharmaceutical companies and PBMs negotiating rebate contracts should expect further challenges from the antitrust agencies, state attorneys general, and private plaintiffs. While "miracle cures" to purportedly high drug costs may remain elusive, companies should carefully consider how their employees and agents characterize rebating strategies in internal documents and communications with customers to ensure that they emphasize their procompetitive benefits and the value provided to the customer. ■

[1] See APCI Advocacy Quarterly: A Federal Update (June 27, 2023), https://www.apcinet.com/APCINews/TabId/416/ArtMID/1695/ArticleID/6389/APCI-Advocacy-Quarterly-A-Federal-Update.aspx.

[2] *Federal Trade Commission Report on Rebate Walls* (May 2021), https://www.ftc.gov/reports/federal-trade-commission-report-rebate-walls.

[3] *FTC Launches Inquiry Into Prescription Drug Middlemen Industry* (June 7, 2022), https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemen-industry.

[4] *Policy Statement of the FTC on Rebates and Fees in Exchange for Excluding Lower Cost Drug Products* (June 16, 2022), https://www.ftc.gov/legal-library/browse/policy-statement-federal-trade-commission-rebates-fees-exchange-excluding-lower-cost-drug-products.

[5] ASPE Office of Health Policy, *Price Increases for Prescription Drugs, 2016-2022* (Sept. 30, 2022), https://aspe.hhs.gov/reports/prescription-drug-price-increases.

[6] *Shire US, Inc. v. Allergan, Inc.*, 375 F. Supp. 3d 538, 557 (D.N.J. 2019) (noting that rebate contracts are not inherently anticompetitive); *see also* Fed. Trade Comm'n, *Statement of Commissioners Christine S. Wilson and Noah Joshua Phillips Regarding the Commission's Report to Congress on Rebate Walls* (2021).

[7] *Fed. Trade Comm'n Report on Rebate Walls* at 2; *see also* Jay Hancock and Sydney Lupkin, *Secretive "Rebate Trap" Keeps Generic Drugs for Diabetes and Other Ills Out of Reach*, KFF Health News (Jan. 18, 2019), https://kffhealthnews.org/news/secretive-rebate-trap-keeps-generic-drugs-for-diabetes-and-other-ills-out-of-reach/.

[8] *Fed. Trade Comm'n Report on Rebate Walls* at 2-3.

[9] David Balto, *FTC Must Tackle Anti-Competitive Drug Rebate Practices*, Law360 (May 17, 2019), https://www.law360.com/articles/1159812/ftc-must-tackle-anti-competitive-drug-rebate-practices.

[10] Wayne Winegarden, *Tear Down This Wall: Documenting the Patient Costs Created by Anti-competitive Rebate Walls*, PRI Center for Medical Economics and Innovation (December 2020).

[11] *Id.* at 4.

[12] *Id*. at 5.

[13] Casey B. Mulligan, *NBER Working Paper Series: Restrict The Middleman? Quantitative Models of PBM Regulations and Their Consequences*, Becker Friedman Institute for Economics at University of Chicago (March 2023).

[14] Fiona M. Scott Morton & Zachary Abrahamson, *A Unifying Analytical Framework for Loyalty Rebates*, 81 Antitrust L.J. 777 (2017).

[15] While the rebate wall theory of antitrust harm has garnered increased attention in recent years, litigants have brought cases alleging analogous claims for decades. *See e.g., SmithKline Corp. v. Eli Lilly and Co.*, 575 F.2d 1056 (3d Cir. 1978) (discussing Eli Lilly's rebating practices); *J.B.D.L. Corp. v. Wyeth-Ayerst Lab'ys, Inc.*, No. 1:01-CV-704, 2005 WL 1396940, at *17 (S.D. Ohio June 13, 2005) (granting summary judgment on plaintiffs' rebate wall theory for failing to show a "causative link between Wyeth's PBM contracts and Wyeth's price increases."); *Castro v. Sanofi Pasteur, Inc.*, 2012 WL 12516572, at *3 (D.N.J. Aug. 6, 2012) (denying motion to dismiss on rebate wall theory where purchasers had been specifically informed that they may not purchase competing products while on a Sanofi contract without facing penalties and the rebating contracts were entered into right after a competitor had released its product and captured almost 20% market share in the relevant market).

[16] Some antitrust claims involving rebates in other contexts have moved past summary judgment. *See, e.g.*, *LePage's Inc. v. 3M*, 324 F.3d 141, 144 (3d Cir. 2003) (transparent tape market); *McWane, Inc. v. F.T.C.*, 783 F.3d 814 (11th Cir. 2015) (domestically manufactured pipe fitting market); *ZF Meritor, LLC v. Eaton Corp.*, 696 F.3d 254, 265 (3d Cir. 2012) (heavy-duty transmissions market); *Cascade Health Sols. v. PeaceHealth*, 515 F.3d 883, 891 (9th Cir. 2008) (primary and secondary acute care hospital services market); *United States v. Dentsply Int'l, Inc.*, 399 F.3d 181 (3d Cir. 2005) (dental supplies market).

[17] *Eisai, Inc. v. Sanofi Aventis U.S., LLC*, 821 F.3d 394 (3d Cir. 2016).

[18] *Pfizer Inc. v. Johnson & Johnson*, 333 F. Supp. 3d 494 (E.D. Pa. 2018).

[19] Hailey Konnath, *J&J Settles Pfizer's Antitrust Suit Over Remicade Biosimilar*, Law360 (July 21, 2021), https://www.law360.com/articles/1405274/j-j-settles-pfizer-s-antitrust-suit-over-remicade-biosimilar. The FTC reportedly opened an investigation into J&J's conduct with respect to Remicade as well. *See FTC Case Against J&J's Remicade Inches Toward Litigation as FTC Considers Consumer Protection Count*, The Capitol Forum, Vol. 11 No. 471 (September 12, 2023).

[20] *In re EpiPen Mktg., Sales Pracs. & Antitrust Litig.*, 507 F. Supp. 3d 1289 (D. Kan. 2020).

[21] *In re EpiPen Marketing, Sales Pracs. & Antitrust Litig.*, 44 F.4th 959 (10th Cir. 2022).

[22] Redacted Opinion, Dkt. No. 525, *Indivior v. Alvogen*, No. 17-CV-7106-KM-CLW (D.N.J. July 10, 2023).

[23] Stipulation & Order of Dismissal, Dkt. No. 548, *Indivior v. Alvogen*, No. 17-CV-7106-KM-CLW (D.N.J. November 9, 2023).

[24] *Regeneron Pharms., Inc. v. Amgen Inc.*, 2023 WL 1927544, at *1 (D. Del. Feb. 10, 2023).

[25] The FTC and state AGs have also challenged rebating practices outside of the drug context in recent years. For example, in *FTC v. Syngenta Crop Protection AG*, 2024 WL 149552, at *1 (M.D.N.C. Jan. 12, 2024), federal and state enforcers allege that Syngenta and Corteva—two major manufacturers of crop-protection products—have run "loyalty discount programs" that allegedly offer discounts to distributors to limit their buying of generic crop-protection products. *Id*. On January 12, 2024, the court denied the defendants' motion to dismiss. *Id*.

[26] Redacted Complaint, Dkt. No. 7, *Fed. Trade Comm'n v. Amgen Inc.*, No. 23-CV-3053 (N.D. Ill. May 16, 2023).

[27] *Biopharmaceutical Giant Amgen to Settle FTC and State Challenges to its Horizon Therapeutics Acquisition* (Sept. 1, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/09/biopharmaceutical-giant-amgen-settle-ftc-state-challenges-its-horizon-therapeutics-acquisition.

[28] *In re Insulin Pricing Litig.*, No. MDL 3080, 2023 WL 5065090 (U.S. Jud. Pan. Mult. Lit. Aug. 3, 2023).