The $356 Billion *Margin Trap*

A COMMERCIAL LEADERSHIP BRIEF FOR CHIEF COMMERCIAL OFFICERS

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Gross-to-net is *eating your* commercial strategy alive.

I spent 20 years in pharma commercial leadership. I've never seen anything quite like what's happening right now with gross-to-net — and most CCOs I talk to are running finance models that weren't built for it.

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$356B

THE GROSS-TO-NET SPREAD · 2024

That's how much the industry gave back in **PBM rebates, government discounts, 340B obligations, and chargebacks** — before a single dollar of net revenue was recorded. The largest spread in history. And it grew **7% year over year.**

Drug Channels Institute confirmed it in July 2025. Three PBMs now control 80% of prescription claims. They don't negotiate. They set terms.

The result: manufacturers must price high to fund the rebates required to reach the patients their drugs were built to serve. A $500 list price generating $180 in net revenue. The rest? Gone before it was ever earned.

Then the IRA arrived. Maximum Fair Prices took effect January 1, 2026. These aren't contract negotiations — they're regulatory ceilings. The finance models most companies are running weren't built for this.

In February 2026, Model N surveyed 429 senior pharma leaders. 99% said GTN has grown more complex. Not 80%. Not 90%. Virtually unanimous.

> *"The gross-to-net problem doesn't just compress your margin. It drives patients off therapy before they ever fill their second prescription."*

But here's what most commercial strategy discussions are still missing. When PBMs push your drug to a non-preferred tier, patients face higher copays. When copay accumulators strip manufacturer assistance, they abandon.

IQVIA found that 27% of all written prescriptions are never filled. In specialty, Pharmaceutical Executive reported a 50% abandonment rate before the second fill.

This is the double tax nobody's naming openly.

◆ THE MECHANISM ◆

You paid twice. *You collected once.*

◆ TAX #1

$356B

The Access Tax

You pay the PBM to get on formulary. Net revenue shrinks before the drug is ever dispensed. A $500 list price yields roughly $180 in net revenue.

◆ TAX #2

35–50%

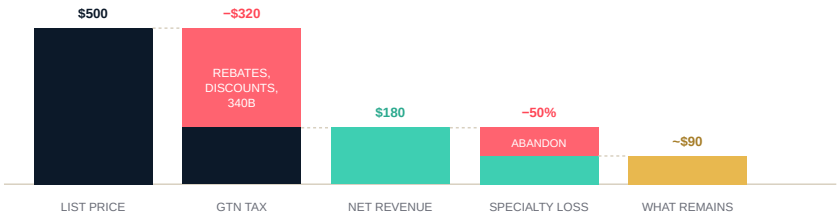
The Abandonment Tax

That same system drives 35–50% of initiated patients off therapy before they ever come back for a refill. You paid for access. You lost the patient.

FIG. 1 · THE REVENUE WATERFALL

$500 list price → what actually reaches the P&L

A representative breakdown of a single prescription through the GTN and abandonment gauntlet.



Source: Drug Channels Institute (2025); IQVIA (2025); Pharmaceutical Executive (2026). Illustrative.

The old playbook — raise list prices to fund rebates, build call centers to catch patients — is broken. List prices are being cut. Call centers are being spam-flagged. The window to prevent abandonment is Days 3 through 30 post-initiation. Most hub models are missing it entirely.

So what does a CCO actually do? Protect the revenue you already paid to access. The patient who persists is worth 10x the patient who abandons after month one — regardless of formulary tier.

Persistence comes down to trust. Patients who feel connected to the clinical voice that prescribed their medication stay on therapy. The prescribing physician is the highest-trust behavior-change asset in medicine. The problem is most manufacturers have no scalable way to extend that voice beyond the office visit.

SMS does. Physician-led video content delivered at the moments of highest lapse risk — 98% open rates, read within minutes — keeps the physician's voice in the patient's life when it matters most.

◆ THE 72-HOUR WINDOW

When decisions actually get made

Patients don't decide in the exam room. They decide at home, in the 48–72 hours after the script is written — while bombarded by Google, TikTok, and well-meaning family.

Days 3–30 post-initiation are the highest-risk window for lapse. Most hub models aren't built to intervene here.

In a world where GTN is compressing what you earn per unit, every unit from a patient who stayed *is* the business model.

Keeping them is the strategy.

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◆ THE CCO PLAYBOOK ◆

What it means for *you* — and what you can do about it.

If you're running commercial at a pharma company in 2026, here's the uncomfortable reality: the levers you were hired to pull are getting shorter every quarter. Here's what's actually in your control.

◆ ACTION #1

Audit your abandonment, not just your access.

Most CCO dashboards obsess over formulary wins. Few track what happens Days 3–30 post-script. If your brand team can't tell you the second-fill rate for your top 3 payers, you're managing half the P&L.

◆ ACTION #2

Re-underwrite the hub.

If your hub's open rate is under 20% and its call-completion rate is under 30%, it's not a hub — it's a cost center. The spam-flagging crisis is real. Physician-led SMS hits 98% open rates within minutes.

◆ ACTION #3

Re-price persistence internally.

A persisted patient is worth 10x an abandoned one. But most commercial compensation plans still reward scripts written, not scripts filled twice. Fix the incentive. The behavior follows.

◆ ACTION #4

Extend the physician voice.

The prescribing physician is the highest-trust behavior-change asset in medicine. Nothing else moves adherence like their voice. The CCOs winning in 2026 are the ones who figured out how to scale it beyond the office visit.

◆ THE BOTTOM LINE FOR CCOS

The rebate war is over. You lost. So did everyone else.

The next commercial frontier isn't price negotiation — you've already paid. It's revenue retention. Every patient who persists is a unit you already bought access for. Letting them abandon is the single most expensive unforced error on your P&L right now. And unlike GTN, it's the one part of the equation you still fully control.

◆ A 30-MINUTE CONVERSATION WORTH HAVING

Let's talk about *what persistence looks like* when the physician voice reaches the patient at home.

hoot.health →

Reply to this email or reach Bob directly at **bob@gethoot.com**

SOURCES Drug Channels Institute (July 2025) · Model N / Pharmaceutical Commerce (Feb 2026) · Argano (Jan 2026) · IQVIA Institute (2025) · Pharmaceutical Executive / CareTria (March 2026)