NATIONAL HEALTH COUNCIL

August 17, 2026

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Ranking Member Wyden:

The National Health Council (NHC) is pleased to respond to your request for information (RFI) on "Commonsense Policy Options to Lower Drug Prices for Patients." We appreciate the opportunity to provide input on this important topic for patients. The ability to afford and access medications is critical for patients, as is the continued development of new treatments. All policy options should lower what patients actually pay, preserve access to clinically appropriate treatments, avoid shifting costs elsewhere in the system, support continued innovation, and include meaningful patient input.

The NHC unites nearly 200 national organizations—including leading patient groups, research institutions, providers, caregivers, and businesses across the health care sector—to drive patient-centered health policy. Representing 200+ million Americans with chronic diseases and disabilities, the NHC strengthens its members' collective influence to expand access to quality, affordable, and equitable health care. The NHC fosters collaboration to shape policies that reflect the needs of patients.

Efforts to address drug pricing are often piecemeal. The NHC appreciates that the RFI takes a more holistic approach. These efforts have also often focused on benefits to the health care system without addressing patients' out-of-pocket costs. Together, the RFI and its companion efforts focused on coverage and access to long-term care represent significant progress toward addressing broken aspects of our health care system.

Financial pressures across the system can directly affect patients through higher copays, coinsurance, and other out-of-pocket costs. The NHC appreciates that the RFI addresses many issues that directly affect what patients pay and prioritizes policies designed to benefit them. At the same time, reductions in federal, plan, or system spending should not be assumed to improve affordability unless savings reach patients, and any reforms must still preserve timely access to clinically appropriate treatments. Policies should also be evaluated for whether they could shift costs onto patients through higher premiums, increased utilization management, narrower formularies, or reduced access to pharmacies and providers.

The NHC looks forward to continued collaboration with the Committee to ensure that reforms are meaningful, sustainable, and centered on the needs of people with chronic diseases and disabilities. The comments below focus on proposals for which the NHC

can offer a distinct patient-centered perspective. They should not be interpreted as taking a position on every concept included in the RFI.

Changes to Medicare Drug Price Negotiation Program (MDPNP)

The RFI includes several questions about the type and number of drugs that will be negotiated under the Medicare Prescription Drug Negotiation Program (MDPNP). A smooth and effective negotiation process that helps contain overall spending and reduce costs for patients is important. However, meaningful patient engagement is also critical to the program's implementation.

The NHC has worked with the Centers for Medicare & Medicaid Services (CMS) to establish formal opportunities for public engagement in the negotiation process and secure continued improvements in each cycle. The NHC supports patient groups that participate in the process each year and compiles their experiences and recommendations in an annual report shared with CMS.[1,2] The report for Initial Price Applicability Year (IPAY) 2028 is in development and will be shared with the Committee when available.

In addition, the NHC is closely monitoring any unintended access and affordability issues resulting from the MPDNP. Although Part D and Medicare Advantage (MA) plans cover all drugs subject to negotiation, patient groups are concerned that plans could be incentivized to reduce access to these drugs through formulary tier placement and increased utilization management.[3,4,5] While coverage is required for negotiated drugs, concerns remain that inappropriate use of utilization management could delay or restrict access.

Any expansion or acceleration of the MDPNP should be accompanied by an assessment of effects on patient access, development in areas of unmet need, treatment options for small patient populations, generic and biosimilar competition, and CMS' capacity to conduct a meaningful and transparent process. Policymakers should also avoid relying solely on time since approval or aggregate spending when clinical context, the availability of alternatives, the degree of therapeutic benefit, or the needs of people with rare or difficult-to-treat conditions may warrant additional consideration.

The NHC asks the Committee to:

- Codify patient engagement in the MPDNP, including direction on how patient input will be considered;
- Create a separate patient engagement track for input beyond the formal information collection request;

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[1] Amplifying-the-Patient-Voice-Roundtable-and-Recommendations-on-CMS-Patient-Engagement-1.pdf
[2] nationalhealthcouncil.org/wp-content/uploads/2025/08/Amplifying-the-Patient-Voice-Reflections-and-Recommendations-from-second-cycle.pdf
[3] The IRA Has Improved Coverage of Drugs Selected for Medicare Price Negotiation | KFF
[4] https://www.iqvia.com/locations/united-states/blogs/2026/07/rejection-rates-unchanged-by-mfp-drug-coverage-requirement
[5] https://www.magnoliamarketaccess.com/insight/medicare-part-d-cost-sharing-changes-2026/

- Require CMS to publicly describe how patient input influenced negotiation decisions and implementation; and
- Instruct CMS to monitor and respond to access or affordability issues resulting from unintended consequences of negotiation, including changes in formulary placement, utilization management requirements, pharmacy claim rejection rates, appeals, prescription abandonment, and switching to non-negotiated products.

Most Favored Nation

The NHC recognizes policymakers' legitimate interest in understanding international pricing differences and pursuing affordability solutions. Any approach, however, should be carefully evaluated for its impact on patient access, continued innovation, and patient-centered decision-making.

One option under consideration, the Most Favored Nation (MFN) pricing model, seeks to lower costs by tying prices in the United States to those in other countries. Although international prices may provide useful context, they reflect distinct health priorities and financing structures, which often differ substantially from those in the United States. International prices may also reflect different treatment availability, budget constraints, clinical practices, and methods of evaluating value. Automatically applying foreign-based prices in the United States could therefore affect patient access and incentives for continued investment in new and improved therapies.

Importantly, tying U.S. drug prices to those set in foreign countries could import coverage restrictions or value judgments, such as those based on quality-adjusted life years (QALYs), that may not reflect the needs and preferences of U.S. patients and policymakers. These value judgements may also discriminate against older adults and people with chronic illnesses and disabilities. Pricing models in other countries also may not incorporate patients' perspectives and fail to reflect their needs and values. International prices may provide useful contextual information, but they should not automatically determine U.S. payment or access policies.

Policymakers must act to ensure that any efforts to reduce patients' out-of-pocket costs for medicines achieve that goal and protect timely access to care. Americans seek health care system reforms that are guided by and deliver what matters most to them: timely access to affordable care, support in managing chronic conditions, access to new treatments, and the ability to make informed choices.

Out-of-Pocket Caps

The NHC applauds the Committee's efforts to address the out-of-pocket (OOP) costs that patients face at the pharmacy counter. The annual Part D OOP cap established by the Inflation Reduction Act (IRA) was a top affordability priority for patients in the legislation. Implementation of the cap, which was established at $2,000 in 2025 and is indexed in subsequent years, closes a major gap in financial protection and access for Medicare beneficiaries, particularly those with chronic diseases and disabilities.[6]

[6] Substantial variation among Medicare beneficiaries in the impact from 2025 Part D out of pocket spending caps - PMC

In addition, the $35 cap on insulin costs for Medicare beneficiaries has improved both affordability and access for many.[7] Making medications that help manage chronic diseases more affordable is in everyone's best interest: it improves access and adherence and can help avoid more costly interventions later by preventing unnecessary disease progression.

Another patient affordability initiatives including in the IRA is the Medicare Prescription Payment Plan (MPPP), which allowed Medicare beneficiaries to spread the costs of their prescriptions over the year. The NHC is concerned that uptake remains low and awareness of the program remains limited.[8] The NHC recommends efforts to improve awareness and uptake of this important program.

The NHC recommends that the Committee:

- Extend OOP protections to other parts of Medicare, including consideration of protections for beneficiaries facing substantial cost sharing under Parts A and B;
- Set OOP caps at levels that are developed in consultation with patients;
- Establish a transparent, evidence-informed process, with meaningful patient participation, for identifying categories of chronic-care medications for which cost-sharing caps would materially improve adherence, access, and health outcomes;
- Evaluate both product-specific and aggregate monthly caps, including how different approaches would affect people with multiple chronic conditions who use several medications; and
- Make enrollment in the MPPP available at the point of sale, provide clear information to beneficiaries, and incentivize education and enrollment of beneficiaries.

Increasing LIS Eligibility

The Low-Income Subsidy (LIS) program has increased access by removing financial barriers associated with Part D premiums and cost sharing for Medicare beneficiaries with the lowest incomes, ensuring they can enroll, stay enrolled, and receive the full benefits of Medicare coverage. This targeted support has been a key component in expanding access to health care for low-income seniors and people with disabilities.

Patients whose incomes are modestly above current LIS thresholds often face significant affordability challenges despite appearing ineligible for assistance. Expanding eligibility would reduce these coverage cliffs and help more people with chronic diseases and disabilities afford the medications they need. The NHC supports efforts to raise the eligibility threshold for this program.

Improving access to the LIS program should be a priority. For example, efforts should identify and enroll eligible people and ensure that LIS beneficiaries who currently pay a Part D premium know they may qualify for a plan with a $0 premium. The Committee

[7] Medicare's $35 Insulin Cap Lowered Beneficiary Costs, Increased Use for Some - June 8, 2026 - USC Schaeffer
[8] New Analysis Highlights Opportunities to Improve MPPP Uptake | Avalere Health Advisory

should also consider whether asset tests, enrollment procedures, and periodic eligibility-review requirements create avoidable barriers for beneficiaries who are likely to remain eligible.

Net Versus List Price

The amount beneficiaries are asked to pay at the pharmacy counter may be based on the drug's list price, a negotiated price, a net price, or another pricing basis, while rebates, discounts and other price concessions may be applied elsewhere in the supply chain. This can expose patients to high and unpredictable costs. Cost sharing may be based on a list price that does not reflect the prescription's actual net cost, and the complexity of the pricing process can make it difficult for patients to anticipate what they will owe.

The NHC appreciates the RFI's focus on ensuring that patients' OOP obligations are based on net, not list, prices. Specifically, the NHC recommends that the Committee:

- Ensure that beneficiary cost sharing is based on a price that reflects applicable negotiated discounts and price concessions to the greatest extent operationally feasible, rather than an inflated list price that does not reflect the actual cost of the transaction;
- Require clear, accessible information that allows patients to understand the price on which their cost sharing is based and whether lower-cost alternatives are available;
- Pursue the OOP cap policies described above to mitigate the impact of list-price cost sharing in the absence of net-price policies; and
- Monitor any point-of-sale rebate or net-price policy for effects on premiums and other forms of cost shifting so that one group of beneficiaries is not helped at the expense of another.

Pharmacy Benefit Managers (PBMs)

The role of PBMs in the health care ecosystem has grown significantly in recent years. As PBMs have taken on more functions, their incentives have increasingly shaped plan decisions and may not always align with the interests of patients, employers, and plan sponsors. Issues of particular importance to patients include rebate transparency, spread pricing, conflicts of interest, and formulary placement decisions.

The NHC requests that the Committee define clear responsibilities and prohibited acts for PBMs while maintaining their status as third-party administrators. Specifically, the Committee should:

- Place guardrails around PBM practices to preserve their role as service providers;
- Apply consistent transparency, conflict-of-interest, and accountability requirements across PBMs and affiliated entities based on the functions they perform rather than their corporate labels or ownership structures;
- Prohibit contractual provisions and compensation arrangements that increase patient costs, restrict access to lower-cost alternatives, or prevent plans,

manufacturers, pharmacies, or other entities from pursuing arrangements that could lower patient and plan costs;
- Require disclosure and independent evaluation of transactions involving affiliated pharmacies, rebate aggregators, group purchasing organizations, and private-label products;
- Authorize regulators to address self-preferencing, excessive markups, steering, or other affiliated transactions that increase costs or restrict patient choice; and
- Ensure that PBM and pharmacy reimbursement reforms preserve access to community, independent, specialty, and rural pharmacies and provide reasonable compensation for dispensing and patient-support services.

Incentives for Innovation

The NHC commends the Committee's focus on increasing U.S. leadership in biomedical research. Recent disruptions and uncertainty in federal research funding have raised concerns among patients, researchers, and developers regarding the long-term stability of the biomedical innovation ecosystem. Research grants have been paused and reinstated without a clear assessment of how those disruptions affect the broader research enterprise.

For patients, innovation is meaningful only when it reaches them. Policies should therefore support both scientific discovery and timely, affordable patient access to resulting therapies. Without a clear path to coverage, scientific advances may not translate into patient benefit. Coverage falls within the Finance Committee's jurisdiction, giving the Committee an opportunity to make significant progress.

The NHC recommends that the Committee:

- Work with committees of jurisdiction to increase research funding and direct it toward the areas of greatest need;
- Promote sustained and predictable federal support for basic, translational, and clinical research, including research in areas of unmet need and conditions affecting relatively small patient populations;
- Evaluate all drug pricing policies for their potential effects on research and development in areas of unmet need and smaller patient populations;
- Support recruitment and retention of the scientific and regulatory workforce needed to evaluate emerging technologies and translate discoveries into safe and effective treatments; and
- Improve coordination among research agencies, the Food and Drug Administration, CMS, payers, patients, and developers so that evidence requirements at each step of the process (regulatory review, coverage, and clinical adoption aligned thereby reducing avoidable delays between approval and appropriate patient access while maintaining applicable safety and evidentiary standards.

Increasing Clinical Trial Participation

Clinical trials are essential to advancing new standards of care and improving survival and quality of life for people with cancer and other life-threatening or chronic diseases.

However, enrollment remains a persistent challenge, particularly among underrepresented populations, including certain racial and ethnic groups, older adults, rural residents, and individuals with lower incomes.

Concerns about the cost of participation often prevent patients from enrolling. While insurers typically cover routine medical costs, patients may still face significant cost-sharing obligations, such as deductibles, copays, and coinsurance. Participants may also incur nonmedical expenses, including transportation, lodging, dependent care, lost wages, and meals, particularly when trials require travel or frequent visits. These costs can be especially burdensome when local trials are unavailable or when participation requires frequent in-person monitoring. Patients receiving care in community-based settings often have limited access to trials and face greater travel burdens when participation requires visiting a distant academic center.

Financial barriers also contribute to gaps in clinical trial participation across income levels and geographies. A recent study found that, compared with individuals earning more than $63,000, those earning less than $38,000 were 36%, 47%, and 71% less likely to enroll in clinical trials for prostate, kidney, and bladder cancer, respectively.[9]

To address these concerns, the NHC recommends that the Committee:

- Advance the Clinical Trial Modernization Act, including its provisions intended to reduce financial barriers to participation and provide appropriate legal clarity regarding assistance with trial-related cost sharing while maintaining safeguards for informed consent, voluntariness, privacy, and scientific integrity; and
- Direct the Department of Health and Human Services' Office of Inspector General to provide clear and durable guidance concerning transportation, lodging, meals, dependent care, digital access, compensation for time and burden, and other reasonable forms of participant support, giving sponsors, research sites, and other stakeholders greater certainty while preserving appropriate safeguards for informed and voluntary participation.

Part D Premiums and Plan Stability

Lower costs at the pharmacy counter are important to patients, but policies intended to reduce cost sharing can have unintended consequences if costs are shifted into higher premiums or reduced plan availability. This is particularly important in the stand-alone prescription drug plan market, which serves many beneficiaries enrolled in Traditional Medicare. Patients need both affordable medications and stable access to plans that meet their coverage needs.

The MPPP can help beneficiaries manage substantial prescription costs by spreading payments across the year. However, the program does not reduce a beneficiary's total

[9] Noel, O. D. V., Akgul, B., Bhandari, M., Ramos, F., Joshi, G., Garg, H., Dursun, F., & Mansour, A. (2026). Clinical trial participation in kidney, bladder, and prostate malignancies in the United States: Sociodemographic distribution and impact on survival. Urologic Oncology: Seminars and Original Investigations, 44(6), 176–188. https://doi.org/10.1016/j.urolonc.2026.111065

out-of-pocket liability, and its value depends on whether patients understand the program, receive timely information about their options, and can enroll without unnecessary administrative barriers.

The NHC recommends that the Committee:

- Monitor the effects of prescription drug pricing reforms on Part D premiums, plan availability, benefit design, and beneficiary choice;
- Ensure that policies intended to reduce point-of-sale costs do not simply shift costs into higher premiums or increased utilization management;
- Protect the stability and availability of stand-alone prescription drug plans for beneficiaries enrolled in Traditional Medicare; and
- Improve awareness, enrollment, and usability of the MPPP, including through clear and timely communications developed with input from patients.

Pharmacy Access and Prescription Claim Rejections

Patients rely on community, independent, specialty, and rural pharmacies to dispense medications and to provide counseling, help resolve coverage problems, coordinate with prescribers, and support safe and appropriate medication use. Drug pricing, PBM, and pharmacy reimbursement policies can therefore affect whether patients have reasonable access to pharmacies and whether pharmacies have the resources needed to provide these services.

Patients can also experience delays or interruptions in care when prescription claims are rejected at the pharmacy counter. Although some rejections may reflect appropriate coverage or safety requirements, patients often receive limited information about why a claim was rejected, what steps they can take to resolve the problem, or whether an alternative treatment is available. These problems can be especially disruptive for people with chronic diseases and disabilities who rely on uninterrupted access to medications

The NHC recommends that the Committee:

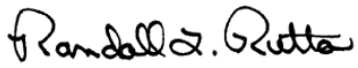
- Ensure that pharmacy reimbursement methodologies reflect the reasonable costs of dispensing medications and providing patient-support services;
- Evaluate the effects of reimbursement reforms on community, independent, specialty, and rural pharmacy participation and patient access;
- Prohibit unpredictable post-adjudication adjustments and other reimbursement practices that undermine pharmacy stability or interfere with continuity of care;
- Require standardized collection and public reporting of prescription claim rejection data, including the reason for rejection and whether the patient ultimately received the prescribed treatment; and
- Ensure that patients and prescribers receive clear, timely, and actionable information about rejected claims, available exceptions or appeals, and clinically appropriate alternatives.

Conclusion

The National Health Council supports policies that lower costs paid by patients, improve transparency and accountability throughout the prescription drug supply chain, preserve access to innovative treatments, and ensure that patient perspectives remain central to policymaking. Reforms should be evaluated not only by their effects on aggregate spending but also by whether they produce measurable improvements in affordability, treatment access, continuity of care, and health outcomes for patients. The NHC appreciates the opportunity to provide comments and stand ready to serve as a resource to the Committee as it evaluates these policy options.

Thank you for your attention to this critical issue. Please contact Kimberly Beer, Senior Vice President, Policy & External Affairs, at kbeer@nhcouncil.org or 202-557-9146 with any questions or requests for additional information.

Sincerely,



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