August 17, 2026

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

Re: Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients

Dear Ranking Member Wyden:

Prescription drug costs are too high, forcing millions of Americans to forgo needed medications every day. Lowering these costs requires multifaceted, market-based reforms to promote competition, increase transparency and hold every participant in the pharmaceutical supply chain accountable while preserving patient access to innovation. We appreciate your longstanding commitment to taking on some of the nation's most complex health care challenges.

ACHP is the only national organization promoting the unique payer-provider aligned model in health care. ACHP member companies collaborate with their provider partners to deliver higher-quality coverage and care to tens of millions of Americans across nearly all 50 states and D.C. Operating on margins of just one to three percent, ACHP member companies are laser focused on lowering costs and delivering better health outcomes, including through access to affordable drugs.

Congress must prioritize reforms that lower the underlying price of medicines, reward clinical value and enhance competition. ACHP's comments are organized around these key themes.

I. Address the Root Cause of High Drug Prices

ACHP supports market-based policies that address the underlying price of prescription drugs while preserving access to innovative therapies. Policies focused solely on limiting patients' out-of-pocket costs may provide short-term relief at the pharmacy counter but overlook the high prices driving those costs throughout the health care system. Congress should prioritize comprehensive approaches that improve accountability across the supply chain and create sustainable solutions for financing high-cost therapies.

Ensure cost-sharing caps reduce, not shift, costs

ACHP cautions against capping cost-sharing for additional types of drugs in Medicare unless these caps are paired with financing that lowers the underlying cost of the therapy. One size-fits-all mandates on insurers do not lower manufacturer's price. Instead, they shift costs from the pharmacy counter to insurance premiums, increasing costs for all enrollees and potentially undermining coverage affordability.

Should the Committee move forward with this proposal, priority should be given to therapies with strong evidence of improved adherence and outcomes, account for the availability of lower-cost alternatives and require meaningful manufacturer responsibility for the cost above the cap. Plans must retain formulary design and negotiating flexibility to secure the lowest-cost, clinically appropriate therapies for patients.

Address added costs in the pharmacy supply chain through pharmacy benefit manager reform

ACHP supports focused reforms that improve transparency, competition and accountability for the total net cost of medicines, including reporting and rebate pass-through pharmacy benefit manager (PBM) requirements enacted in the *2026 Consolidated Appropriations Act*. Congress should build on these reforms by addressing remaining gaps, including transparency requirements for group purchasing organizations and rebate aggregators.

ACHP member companies lead the market in using transparent and flat-fee PBM arrangements, including Scripius by Select Health, Navitus by Aspirus Health Plan, CommunityCare, Geisinger Health Plan, Group Health Cooperative South Central Wisconsin, Medica and OhioHealthy and Pharmacy Benefit Dimensions by Independent Health. These models demonstrate that plans can align pharmacy benefit administration with better care.

Congress should prioritize the creation of a sustainable financing approach for cell and gene therapies

While ACHP understands the committee's work on cell and gene therapies is occurring outside of the bounds of this RFI, there is a significant affordability challenge these drugs pose for community-based plans and an urgent need for a comprehensive solution.

Cell and gene therapies have the potential to revolutionize medicine by bringing lasting relief for life-limiting conditions, including spinal muscular atrophy and sickle cell disease, where few options existed before. However, these treatments can cost up to $4 million for a single dose, with the entire cost incurred upfront. Today's risk-pooling model was not built for this type of concentrated high-copayment – and without mechanisms to spread the risk, access to treatment depends on the financing capacity of the plan a patient happens to be enrolled in. This is a particular concern for small nonprofit plans with lower reserves; as few as two or three cell and gene therapies in a year can leave a plan choosing between delivering lifesaving care and declaring bankruptcy.

ACHP has called on Congress to establish a national risk pool for high-cost cell and gene therapies. The 2027 House proposed Labor-HHS budget also requires CMS to examine the feasibility of a national risk pool. We look forward to continuing communication with the committee on the contours of a national risk pool and working together toward an affordable coverage model for these innovative treatments.

II. Reward clinical value and comprehensive care

ACHP supports coverage models that pair access to prescription drugs with coordinated, evidence-based care that improves patients' long-term health. Policies should account for the clinical services and provider partnerships needed to deliver value. Congress should prioritize approaches that address underlying drug costs, support comprehensive care and distinguish profit-driven practices from nonprofit, provider-aligned models that improve coordination and patient outcomes.

GLP-1 access models must tie financing to comprehensive obesity care and address underlying manufacturer costs

ACHP cautions that mandatory GLP-1 coverage that focuses solely on drug acquisition without addressing the full continuum of obesity care could lead to high prices without improving patient outcomes. A subscription model may create budget predictability, but by itself it does not establish clinically appropriate eligibility, support adherence, address nutrition and lifestyle factors, monitor side effects or measure whether patients achieve durable health improvements. These pieces must be addressed for patients to effectively tackle their chronic condition and maintain success after discontinuing a GLP-1.

ACHP member companies have developed comprehensive obesity-care programs that pair appropriate medication use with clinical monitoring, behavioral health, nutrition and other supports. For example, Minnesota-based HealthPartners obtained a 32 percent decrease in cost trend over six months, while supporting an average patient weight loss of 45 pounds by proactively enrolling GLP-1 candidates in lifestyle coaching. Any federal model should build on this type of comprehensive care.

Any GLP-1 coverage model must include enforceable price concessions from manufacturers and comprehensive lifestyle support. Mandatory participation without these pieces would merely shift the cost of paying for these drugs without a plan to address the underlying reasons for high manufacturer costs or strategies to avoid long-term dependence. For nonprofit, community-based health plans already operating on thin average margins of one to three percent, this cost shifting could lead to higher premiums. Any model that mandates coverage by insurers needs to be comprehensive; coverage criteria should be evidence-based and payment should be linked to outcomes and adherence.

Target Part D program integrity reforms to abusive practices, not provider-aligned care

ACHP shares concerns about profit-driven vertical integration by large national plans. However, blanket margin tests that sweep in all forms of integration penalize nonprofit, provider-aligned plans that coordinate coverage, pharmacy services and clinical care. ACHP member plans operate on a fundamentally different model than publicly traded national insurance conglomerates: they are locally governed, community focused and not driven by shareholder return.

Provider-aligned plans partner closely with clinical teams to advance value-based care, improve coordination and ultimately lower the total cost of care. This partnership allows ACHP member companies to be leaders in preventive care and chronic disease management. For example, ACHP member companies have worked with their provider partners to offer continuous glucose

monitoring for diabetes, an intervention shown to decrease diabetes complications by 80 percent and save up to $400 per patient per year.

Program integrity rules should target clearly defined transactions or transfer-pricing practices that inflate Medicare costs, use consistent reporting standards and apply equally to comparable conduct across ownership models. Congress should avoid policies that treat provider-plan integration itself as evidence of abuse when that integration is being used to deliver coordinated, comprehensive care.

III. Decrease costs through enhanced competition, especially where there is opportunity to improve access to alternatives to brand-name drugs.

ACHP supports policies that foster meaningful competition in the prescription drug market and expand access to safe, effective and lower-cost alternatives. A more competitive market gives patients, health plans and public programs greater leverage against high drug prices while preserving incentives for continued innovation. Congress should build on proven tools that strengthen competition, including removing unnecessary barriers to biosimilar adoption and preserving Medicare's ability to negotiate fair prices for high-cost drugs.

Build on Medicare Drug Price Negotiation, including through incorporation of international reference pricing, and explore pathways to expand to the commercial and employer market

As the only national payer group to endorse the Inflation Reduction Act's drug pricing reforms, ACHP supports building on Medicare Drug Price Negotiation. American patients and purchasers should not continue to pay more than comparable countries for the same medicines. ACHP supports the concept of international reference pricing to make American prices more competitive.

Congress should also explore a pathway for commercial and employer purchasers to benefit from Medicare-negotiated prices while preserving the ability for those purchasers to negotiate a lower net price. As Congress considers expanding the number or timing of negotiated drugs, policymakers should focus on products that drive the greatest cost and provide predictable implementation for patients, plans and manufacturers.

Any price negotiation strategy must preserve formulary flexibility. When a generic or biosimilar becomes available after a brand product is selected for negotiation, plans should not be locked into coverage requirements that prevents them from prioritizing the highest value, most clinically appropriate product.

Accelerate biosimilar competition through removal of the biosimilar interchangeability designation

Increasing biosimilar adoption is a practical way to lower drug costs while maintaining comparable patient outcomes. Biosimilars are typically priced below their brand-name reference biologics and have generated more than $56 billion in savings since entering the U.S. market in 2015. ACHP member companies have achieved significant savings by switching patients to biosimilars. Sanford Health Plan, for example, reduced costs by 95 percent with comparable patient outcomes by moving patients from Humira to a biosimilar alternative.

Congress can accelerate biosimilar competition by passing the *Biosimilar Red Tape Elimination Act* (S. 1954), which would remove the separate interchangeability designation and allow FDA-approved biosimilars to be substituted for their reference biologics. The additional designation is no longer necessary after FDA has completed its rigorous approval process and can delay the availability and uptake of lower-cost alternatives. Additionally, Congress should encourage the Centers for Medicare & Medicaid Services (CMS) to use its existing authorities to accelerate biosimilar adoption.

We look forward to working with the Committee to lower drug prices at their source, improve affordability without shifting costs and strengthen competition. Please contact Christopher DeVore, Associate Director of Legislative Affairs at cdevore@achp.org with any questions or to discuss further.

Sincerely,

Dan Jones

Dan Jones
Senior Vice President, Federal Affairs
ACHP