AMERICAN COLLEGE of RHEUMATOLOGY
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August 17, 2026

The Honorable Ron Wyden
Ranking Member, Senate 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 and members of the Senate Democratic Caucus,

The American College of Rheumatology (ACR), representing over 10,000 rheumatologists and rheumatology interprofessional team members, appreciates the opportunity to support the efforts of the Senate Democratic Caucus to pursue policies that lower drug prices for patients and increase the affordability and accessibility of treatments. Rheumatologists and rheumatology professionals share in this goal, as the high cost of rheumatic disease therapeutics is a top contributor to non-adherence to treatments and corresponding negative health outcomes.[1]

The ACR appreciates your ongoing efforts to engage with stakeholders to improve the American health care system for both patients and physicians. Supporting physicians and practice viability is crucial to ensuring that patients can access the highest quality care in the lowest cost settings, leading to improved health outcomes. To this end, we offer specific recommendations below in response to your questions.

Section 1: Lowering Drug Prices

1. Supporting Uptake of Biosimilars

Physician-administered biosimilars are essential in the treatment of chronic and debilitating conditions, including rheumatoid arthritis, psoriatic arthritis, and other serious rheumatologic and musculoskeletal diseases. **These therapies were introduced to improve access and lower costs; however, current Medicare payment policies often fall short of covering their acquisition costs. This issue stems largely from artificially low average sales prices (ASPs), which are distorted by excessive manufacturer rebates to health plans and pharmacy benefit managers (PBMs) to secure formulary placement.** As a result, many biosimilars are "underwater"—reimbursed below their acquisition cost—making it financially infeasible for

[1] https://acrabstracts.org/abstract/cost-related-medication-burden-for-patients-with-and-without-systemic-autoimmune-rheumatic-diseases/

physicians to provide them in the office setting. Because commercial insurers also base their reimbursement rates for biosimilars off ASP, access for commercially insured children and adults is also limited under the current model.

This challenge is exacerbated by MA plans' step therapy requirements that often mandate use of these biosimilars physician practices cannot afford to provide before patients can access alternative options. When physicians are unable to absorb financial losses or must refer patients to hospital settings, access is delayed or denied entirely. Infusions provided by hospitals may be more expensive and more geographically difficult for patients to access, particularly in rural areas.

In a national survey of rheumatologists, 97% have reported that their practice has been affected by reimbursement rates which are lower than acquisition costs. Of these responses, 91% reported a discrepancy in reimbursement vs. acquisition rates as more pronounced for certain biosimilars than others[2]. The lowest cost medication, the biosimilar, cannot be administered due to economically unviable reimbursement in the current buy-and-bill model. **These circumstances force practitioners to make difficult financial decisions between the following: take a financial loss to administer needed therapy or to send patients away to hospital infusion centers, where the cost to the health system can increase significantly. We recommend specific policy solutions later in this response to reverse this misalignment of jeopardizing patient access in order to maintain a solvent business.**

2. **Unintended Consequences of International Reference Pricing (IRP)**

While intended to lower drug costs, IRP models raise significant concerns for patient access to rheumatology treatments. Reimbursement caps tied to external benchmarks may fall below acquisition costs for biologics, making it financially unviable for physicians to purchase and administer therapies under buy-and-bill and maintain the provision of care in a community practice setting. More broadly, "most favored nation" pricing approaches risk creating drug access challenges and supply disruptions if manufacturers cannot sustain distribution at reduced prices.

In fact, when CMS most recently proposed a Most Favored Nation (MFN) drug-pricing model, their own data acknowledged that some savings from such a policy would significantly curtail patient access to medications. **In Table 11 of the IFC, CMS states that 9% of MFN savings in the first year will be attributable to patients losing access to medications. That percentage would grow to nearly 20% in subsequent years under the policy.[3]** It is critical that any

[2] Coalition of State Rheumatology Organizations, Explanatory Statement: "Underwater" Biosimilars https://csro.info/UserFiles/file/CSROExplanatoryStatement-UnderwaterBiosimilars.pdf
[3] Most Favored Nation (MFN) Model, 85 Red. Reg. 76180, (Nov. 27, 2020).

attempts to lower the cost of drugs not imperil patient access. The ACR will continue to advocate for policies that preserve physician-administered therapies, ensure reimbursement aligns with actual acquisition and clinical costs, and protect patient choice and continuity of care.

Section 2: Enhancing Prescription Drug Affordability

1. **Expansion of PBM Reforms**

Three PBM companies collectively hold 80% of the market share. Of those, CVS Caremark holds 34%, Express Scripts holds 25%, and Optum RX holds 21%. The latter two companies are owned by insurers. There are 60+ smaller PBMs looking to capitalize on the growing pie as the global PBM market is projected to increase from $495 billion in 2022 to $740 billion by 2029. As mentioned earlier in our response, the business practices of PBMs are ripe for reforms that will result in cost savings for patients covered under Medicare and commercial insurance plans. **The ACR recommends expansion of PBM reforms into ERISA plans, banning spread pricing in all insurance markets, and delinking PBM compensation from the list price of drugs they negotiate for formulary placement as powerful mechanisms for lowering drug costs for patients.**

i. **The PBM Fiduciary Accountability, Integrity, and Reform (FAIR) Act (S. 3549)** would amend the Employee Retirement Income Security Act of 1974 (ERISA) to treat PBMs as fiduciaries, requiring them to place the interests of the health plan and its participants ahead of the PBM's financial interests. In addition, the legislation would require PBMs to provide plan administrators with detailed information regarding the direct and indirect compensation including rebates, administrative fees, and other forms of payment tied to prescription drug pricing. Finally, the legislation also would restrict PBMs' ability to shift responsibility for fiduciary breaches back to plans through contractual indemnification provisions. Together, these requirements would strip PBMs of much of the secrecy and ability to make financial decisions that increase their profits as well as costs for patients.

ii. **The PBM Transparency Act (S. 526)** would require PBMs to report spread pricing and pharmacy fee profits to the Federal Trade Commission (FTC). "Spread pricing" occurs when PBMs charge health plans (employers/insurers) more for prescription drugs than they pay the pharmacy, pocketing the difference (the "spread") as profit.

iii. **The DRUG Act (H.R. 2214)** would replace the current PBM fee structure, where their profits are based on the prices they negotiate for drugs, with flat service fees and require 100% pass-through of negotiated rebates and discounts to health plans to lower premium costs for ERISA plans.

2. Limiting Specialty Drug Tiering and Cost Shifting of Specialty Drugs

Many commercial health insurance policies put vital medications (such as biologic treatments) into "specialty tiers" that require a higher patient cost-sharing. These specialty tiers (Tier IV and higher) require patients to pay "co-insurance," a percentage of the cost of these drugs (often 25 to 33 percent or more), as opposed to a co-pay, a difference that can cost patients hundreds or even thousands of dollars per month for a single medication. Commercial health insurance plans also use co-insurance to force patients to pay a large percentage of the cost of non-generic drugs when their total out-of-pocket spending exceeds an annual threshold.

In an attempt to offset some of these costs, copay assistance programs are offered by pharmaceutical manufacturers as well as independent non-profit patient assistance programs (PAPs) and disease specific charitable organizations. Copay assistance programs cover the patient's drug coinsurance, which in a conventional benefit design is also applied to the patient's annual deductible and out-of-pocket (OOP) maximum. These programs thereby preserve patient access to otherwise unaffordable drugs when OOP expenses are high. Without such assistance, these treatments are out of reach for many patients, and their medical conditions may go untreated or are undertreated, leading to potential joint damage and disability, unemployment, expensive surgeries, and overall higher health care costs.

In response to the high cost of specialty drugs and associated emergence copay assistance programs, insurers have countered with three distinct types of plans that attempt to reduce the amount they are forced to spend to cover specialty drugs[4]. Both **copay accumulator programs** and **copay maximizer programs** prevent manufacturer copay assistance from being applied to patient deductibles or out-of-pocket maximums. With a copay accumulator program which is typically offered by the plan's PBM, the patient's drug costs appear to be covered early in the year but once the copay card runs out, the patient suddenly owes the full cost of the drug until they meet their deductible and OOP maximum. **A study of commercially insured patients with autoimmune disease for whom a copay accumulator adjustment program was instituted did in fact demonstrate a significant reduction in monthly refills, a lower percentage of days covered, as well as an increase in drug discontinuation.[5]** In contrast, copay maximizers offered by third party vendors partnering with the plan's PBM, spread the value of the manufacturer's copay assistance evenly over the entire year so that when the copay card runs out, the increase in patient costs is not as great although they are still responsible for covering their deductible and out-of-pocket maximum.

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[4] (2024). *A primer on copay accumulators, copay maximizers, and alternative funding programs. Journal of Managed Care & Specialty Pharmacy, 30*(8), 883–896.

[5] (2019). *Impact of Co-pay Assistance on Patient, Clinical, and Economic Outcomes, American Journal of Managed Care, 25*(7), 335–340.

Lastly, alternative funding programs (AFPs) are typically administered by a third-party vendor unaffiliated with an individual plan's PBM. AFPs reclassify biologic specialty drugs as "non-essential" or "non-covered," thus removing them from coverage under the patient's insurance plan. Patients are then forced to seek alternative sources of funding with the assistance of the third-party vendor usually through the pharmaceutical company's own patient assistance program (PAP), with the vendor often helping to disguise the patient as "uninsured" so they can apply for assistance.[6] The drug may be provided for free if the patient's income is below a certain threshold but otherwise the patient may be forced to pay the full list price. This process results in a significant administrative burden for the patient and healthcare provider with frequent treatment delays while the denials are appealed even if the patient is eventually approved for drug.

By the end of 2024, more than 40% of commercial insurance plans utilized programs that diverted manufacturers' copay support away from the patient with copay maximizer plans becoming more popular than copay accumulator programs. AFPs have become more attractive for employer self-funded plans, increasing from 6% in 2021 to 14% in 2022[7]. Concerns regarding the legality of AFPs and regulatory risk may explain their lower uptake by commercial health plans.[8]

The ACR strongly opposes excessive patient cost-sharing in specialty cost-tiering practices by insurers and encourages the Senate Democratic Caucus to pursue policies that would limit this practice.

1. **The HELP Copays Act (S. 864)** would force insurers to include manufacturer coupons, non-profit charity assistance, and vouchers when calculating what a patient has paid towards their annual out-of-pocket maximum or deductible. Additionally, it would ban insurance companies and pharmacy benefit managers (PBMs) from pocketing assistance funds while forcing patients to pay their deductibles twice. Finally, it would ensure all prescription drugs covered by a health plan are treated as essential health benefits, so cost-sharing protections apply fully.

3. **Limiting Patient Cost Sharing in Chronic Care Management (CCM) Services**

Under current policy, Medicare beneficiaries are required to pay 20% coinsurance to receive care management services. Many beneficiaries who would be eligible for chronic care management

[6] UnitedHealthcare. (2021). *Copay Card Solutions: Accumulator Benefit flyer*. Retrieved January 3, 2026, from UnitedHealthcare Copay Card Solutions Accumulator Benefit Flyer
[7] Fein, A. J. (2025, February). Why plan sponsors and PBMs are still … Drug Channels. https://www.drugchannels.net/2025/02/why-plan-sponsors-and-pbms-are-still.html
[8] Fein, A. J. (2025, February). Why plan sponsors and PBMs are still … Drug Channels. https://www.drugchannels.net/2025/02/why-plan-sponsors-and-pbms-are-still.html

services are unable to afford any additional out-of-pocket healthcare expense. The data bears out this point: only 4% of eligible Medicare beneficiaries received chronic care management services, approximately 882,000 of a pool of 22.5 million eligible individuals. Moreover, the use of chronic care management services is associated with demonstrably lower cost incurred by the Medicare program. A CMS study that analyzed the cost of patients enrolled in chronic care management compared to un-enrolled patients to the Medicare program found that over an 18-month period, Medicare spent $95 less per patient per month for CCM patients.[9] **To both ensure savings for the Medicare program and increase patient access to vital care, the ACR recommends the removal of cost sharing requirements for chronic care management services though the Chronic Care Management Act (H.R. 8261), led by Representative Suzan DelBene.**

4. Combating Vertical Integration and its Impact on Patient Access to Physicians

Vertical integration is a disturbing trend that only continues to worsen, and physicians are experiencing hardships as well. Optum, a subsidiary of UnitedHealth Group, employs fully 10% of all physicians in the US. Collectively, 22.3% of American physicians are employed by a corporate entity. This is a direct result of a lack of support for independent physician practices through continued cuts to reimbursement under both Medicare and commercial insurers. Rheumatology as a specialty is particularly vulnerable to the impacts of vertical integration, as the cost of rheumatologic care increases dramatically when the setting of care shifts from a physician office to a hospital outpatient setting. The number of beneficiaries receiving care also decreases when the site of care shifts.[10] **The ACR encourages the Senate Democratic Caucus to support rheumatologists in community practice and the patients they serve by addressing the one of chief drivers of high drug prices: vertical integration in healthcare.**

5. Physician Payment in Medicare Part B

It is important to note that physicians have no mechanism by which to control the list prices set by drug manufacturers, rebates pocketed by PBMs, discounts for 340B institutions that are not available to them, but included in calculations, or combat preferred placement of higher priced drugs on formularies. Independent physicians take on substantial risk when they purchase drugs at costs set by outside entities and are forced to merely react to changes in list prices or insurance coverage. Where reimbursement is delayed, reduced, or doesn't fully cover costs, physicians take a financial risk or lose money on every dose they use to treat their patients. Even when

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[9] Office of the Assistant Secretary for Planning and Evaluation. (2022, March 1). Analysis of 2019 Medicare fee-for-service claims for Chronic Care Management (CCM) and Transitional Care Management (TCM) services [PDF]. U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-Descriptive-Analysis.pdf

[10] Jonathan S. Levin & Xiaoxi Zhao & Christopher Whaley, 2025. "**Impact of hospital-physician vertical integration on physician-administered drug spending and utilization**," Health Economics, John Wiley & Sons, Ltd., vol. 34(2), pages 345-367, February.

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reimbursement is theoretically adequate, cashflow may disrupt care. Claims denials, coding errors, and slow payments can leave practices in limbo for weeks or months. **Smaller practices, rural clinics, and safety net clinics are especially vulnerable as they cannot absorb financial risk like large hospital systems and are at risk of acquisition by larger health systems or private equity.**

The ACR notes that while there are structural issues with the ASP + 6% formula currently used to reimburse physicians under Medicare Part B, the add-on payment itself does not represent an overpayment, as it is necessary to cover important costs that physicians incur to administer these drugs safely. For example, a small practice providing critical infusion therapies applies the 6% add-on to the cost of storing the drug at the appropriate temperature, retaining infusion nurse(s) who can safely administer these treatments, and maintaining the additional square footage and equipment necessary to provide infusions on site.

To ensure patient access to treatments, any replacement of the ASP + 6% formula must:

- Be adjusted annually for inflation.
- Completely cover the actual cost of acquiring the drug by an independent practice while also:
    - including payment for maintaining staff, facilities, and proper equipment for the treatments that reflect the actual cost of providing care.
- This sum should not be impacted by rebates or discounts accessible to other institutions, including, but not limited to, 340B rebates.

The ACR supports policies that would lower drug prices for patients, ensure the accessibility of safe and effective treatments, and improve health outcomes. We thank the Senate Democratic Caucus for the opportunity to provide input as to how Congress might achieve these goals. Please contact Paige Colston, Senior Manager of Congressional Affairs & Advocacy, at pcolston@rheumatology.org with any questions.

Sincerely,

Amanda Meyers, MD, FACR
Chair, Government Affairs Committee