August 17, 2026

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

Dear Ranking Member Wyden:

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

West Health appreciates the opportunity to respond to the Senate Finance Committee Minority Staff's Request for Information (RFI) on Commonsense Policy Options to Lower Drug Prices for Patients. West Health commends the Committee's continued leadership in examining policy solutions to improve prescription drug affordability and address the market dynamics that drive unnecessarily high costs for patients and the healthcare system.

Solely funded by philanthropists Gary and Mary West, West Health is a family of nonprofit and nonpartisan organizations combining applied medical research, advocacy, policy analysis, and high-impact grantmaking to improve care, lower costs, and enhance the aging experience for seniors and all Americans.[1]

West Health brings an independent, data-driven perspective to our prescription drug policy work, which we view as central to health system transformation. We focus on identifying solutions that balance innovation with fiscal reality - improving patient affordability while addressing the underlying market dynamics that weaken competition, encourage prices that exceed drug's clinical value, and increase costs across the healthcare system.

In the comments below, West Health offers targeted recommendations on priorities most aligned with our mission:

1. Build upon Medicare drug price negotiation and pursue policies that better align drug prices and supply chain incentives with clinical value.
2. Pair patient affordability initiatives with reforms that address the root causes of high prescription drug costs.
3. Strengthen clinical evidence through addressing barriers to older adults' participation in clinical trials.

West Health is pleased to offer the Committee technical assistance, drawing on our original research, public opinion surveys, and partnerships with leading researchers and

[1] These organizations include the Gary & Mary West Foundation, the West Health Institute, and the West Health Policy Center.

health systems. Our Medicare Negotiation Outcomes Calculator, developed in collaboration with Verdant Research, allows us to comprehensively assess tradeoffs between different reforms and identify ways to enhance desired outcomes while mitigating potential downsides. Our data and analytic tools are particularly useful for analyzing the effects of negotiation policies of interest to the committee, including increasing the number of drugs negotiated, changing time to negotiation, and the selection of orphan drugs.

Section I: Lowering Drug Prices

West Health believes every American should have access to needed prescription medications that genuinely improve outcomes without facing financial hardship. We view prescription drugs as a powerful tool for driving health system transformation that is currently hampered by misaligned financial incentives. Persistent failures in the prescription drug market have contributed to unsustainably high costs for patients, taxpayers, employers, and the healthcare system. These market dynamics warrant thoughtful government intervention to improve affordability, strengthen competition, and better align drug prices with the value they deliver.

Bolstering Medicare's Ability to Negotiate Lower Drug Prices

The Inflation Reduction Act (IRA) established an important foundation by allowing Medicare to negotiate prices for a limited number of high-cost drugs, generating savings for beneficiaries and taxpayers while beginning to better align drug prices with the value they provide. The IRA has already made a critical difference in rationalizing the way we pay for drugs. However, recent changes to the program, as well as evolution in the market for prescription drugs, present challenges for the program's ability to reach its full savings potential, which is critical for the sustainability of Medicare prescription drug coverage. The Congressional Budget Office's most recent estimates, however, suggest that two of the IRA's cost-saving provisions, negotiation and inflation rebates, have not kept pace with the increased spending associated with provisions that improved beneficiary access and affordability under Medicare Part D.[2]

West Health strongly supports Medicare drug price negotiation as one of the most effective tools for improving prescription drug affordability and reducing unnecessary spending across the healthcare system. To inform this discussion, West Health partnered with Verdant Research to build the Medicare Negotiation Outcomes Calculator, an interactive tool that models how changes to key program parameters – the number of drugs negotiated, eligibility timelines, and orphan drug exemptions – would affect federal savings relative to current law.

We used this model to assess the RFI's proposed changes to negotiation eligibility and scope, and focus our comments below on the parameters where our modeling offers the clearest evidence:

[2] Congressional Budget Office. *Developments in CBO's Projections for Medicare Part D*. 29 July 2026, https://www.cbo.gov/system/files/2026-07/62549-Medicare-Part-D.pdf.

- Expanding Medicare drug price negotiation by factoring in international prices
- Expanding Medicare drug price negotiation and finding a pathway to lower drug prices in the commercial market
- Allowing the Health and Human Services Secretary to negotiate more drugs each year
- Allowing the Secretary to negotiate prices earlier in drug product lifecycles and when such negotiations should occur on small molecule and biologic drugs
- Eliminating the blockbuster drug bailout included in H.R.1, the 2025 Reconciliation Act, and replacing it with the No Big Blockbuster Bailouts Act (S. 3019)

In addition, we provide other suggestions in support of the Committee's efforts:

- Preserving and strengthening the implementation of Maximum Fair Price (MFP) at point of sale

Expanding Medicare Drug Price Negotiation by Factoring in International Prices

We appreciate the Committee's request for feedback on including Most Favored Nation (MFN) prices in the negotiation program. **West Health supports strengthening the Centers for Medicare & Medicaid Services' (CMS) ability to negotiate even greater savings by referencing other countries' prices**.

Prices in other countries are significantly below those in the United States, particularly for drugs without branded competitors or that are in protected classes. Using the Medicare Negotiation Outcomes Calculator, we find that applying MFN prices as proposed in the Elijah E. Cummings L*ower Drug Prices Now Act* (H.R.3, the original House version of the Medicare negotiation legislation) would increase savings from $61.7 billion to $94.7 billion over the next 5 Initial Price Applicability Years (IPAYs) to be selected, even with no other changes to the law (see ***Table 1*****Error! Reference source not found.**).

The inclusion of international prices in CMS offer ceilings also points to two additional avenues for negotiating better prices: market power and value assessment.

First, CMS should consider the value of the market it is offering to the manufacturers of selected drugs. Other countries achieve lower prices by centralizing their negotiating power. This is true not only of countries with single payer healthcare, but also among those that have multiple payers (e.g., Germany or Canada). While the factors already enumerated in 1194(e) of the Social Security Act can inform what CMS offers in negotiation, Congress can bolster them by instructing CMS to factor in the value of the market opportunity that access to its beneficiaries represents to manufacturers of selected drugs.

Second, other countries combine their market power with value assessment, which we also support. Value assessment does not necessarily require the use of quality-adjusted life years (QALYs) or cost-effectiveness analysis. Many countries use other approaches, such as budget impact analysis or multi-criteria decision-making, to determine whether to cover a drug and how much to pay for it.

Table 1. *Projected Outcomes (Federal Savings and Number of Drugs Selected) of Factoring International Prices into Medicare Negotiation (2029-2033)*

	Federal Savings (Billions)	Number of Drugs Selected for Negotiation
Current Law	$61.7	87
Applying 120% Most Favored Nation prices in lieu of Maximum Fair Price (H.R.3)	$94.7	87

Source: West Health–Verdant Research Medicare Negotiation Outcomes Calculator.

One critique of international reference pricing, however, is that these approaches, and the coverage and prices associated with them, are shaped by norms and preferences that are different from those of United States and the Medicare population. For this reason, we urge the Committee to incorporate U.S. and Medicare-specific assessments of value into its negotiations, particularly if other reforms result in drugs being selected earlier in their lifecycle. Negotiation on the basis of value is a critical tool for encouraging better innovation: it sends a clear signal to innovators that the best drugs get the best prices.

Expanding Medicare Drug Price Negotiation and Finding a Pathway to Lower Drug Prices in the Commercial Market

In alignment with the RFI discussion, **West Health supports expanding negotiated prices and inflation rebates to the commercial market**. Both policies have precedent (H.R.3 and IRA legislative history) and in many cases, manufacturers have reduced list prices on their own to avoid the costs of Medicare and Medicaid inflation rebates as well as the complexities of implementing Maximum Fair Price.

In pursuing such policies, the Committee should, however, be prepared to address two complexities. First, expansion beyond Medicare will have very different financial consequences for manufacturers depending on the market share of their drug in the commercial payer population. Coupling expansion of negotiation to the wider market with other reforms (i.e., referencing international prices or selecting drugs sooner in their life cycle) could have a substantially greater effect on manufacturer revenue than negotiation has had so far, and could disproportionately affect drugs used widely outside of the program as well.

Second, grounding selection for negotiation on use and spending in Medicare could mean that drugs more widely used by commercially insured patients are never negotiated at all. Just as expansion could overcorrect in one direction, restricting selection criteria too narrowly risks under correcting in the other – in turn, limiting the access and affordability benefits for this population.

We encourage the Committee to explore avenues for expanded access to negotiated prices through means that meet three aims:

1. Tailored to the affordability and access needs of individuals with coverage through their employer or Affordable Care Act plans;

2. Preserving the benefits of negotiation to Medicare and its beneficiaries; and
3. Depending on scope, coupled with policies to encourage innovation, such as value-based pricing for younger drugs.

Allowing the Health and Human Services Secretary to Negotiate More Drugs Each Year

West Health supports expanding the number of drugs negotiated each year, including a minimum annual selection requirement, with flexibility for the Secretary to negotiate additional qualifying single-source drugs beyond that floor. Our analysis of these options revealed that this policy change requires careful evaluation and is most powerful when paired with reforms to make selections based on savings opportunity and to expand negotiation eligibility.

For example, adding 5 drugs per year to the 20 called for in current law would result in the selection of one more drug over 2029 – 2033, generating $100 million in additional federal savings (see ***Table 2***).

Our modeling also suggests that increasing the number of drugs selected each year can produce lower-than-anticipated savings, since it shifts both the mix and timing of selection between short- and long-monopoly products. One way to address this is to weigh the selection of additional drugs based on their near- or long-term savings potential, or to incorporate lower offer ceilings sooner in a drug's lifecycle.

Additional flexibility to select more drugs is inherently limited by the scope of negotiation eligibility. Under current law, the number of negotiation-eligible drugs is declining, both because of the expanded orphan drug exemption enacted under H.R.1, the 2025 budget reconciliation act (Pub. L. No. 119-21), and because older drugs are beginning to see generic and biosimilar entry that makes them ineligible for negotiation.

We project that current criteria will not yield enough negotiation-eligible drugs to fully populate the annual roster of 20 drugs a year after 2031. Pairing a minimum selection requirement with policies that expand negotiation eligibility significantly improves the impact. For example, negotiating 20 drugs a year while eliminating all exemptions for orphan drugs would increase the total number negotiated to 100 over the model timeframe and raise federal savings to $80.9 billion (see ***Table 2***). Building on this change by increasing the number to 25 per year would result in 20 more drugs being negotiated and savings of $84.7 billion (see ***Table 2***).

Table 2. *Projected Outcomes (Federal Savings and Number of Drugs Selected) of Potential Changes to Medicare Negotiation (2029-2033)*

	Federal Savings (Billions)	Number of Drugs Selected	Year of Drug Selection for Negotiation				
			2029	2030	2031	2032	2033
Current law (20 per year)	$61.7	87	20	20	20	16	11
Current law with number of drugs selected increased to 25 per year	$61.8	88	25	25	17	10	11
Making no exemptions for any drugs with orphan indications (20 per year)	$80.9	100	20	20	20	20	20
Making no exemptions for any drugs with orphan indications with number of drugs selected increased to 25 per year	$84.7	120	25	25	25	25	20

Source: West Health–Verdant Research Medicare Negotiation Outcomes Calculator.

Allowing the Secretary to Negotiate Prices Earlier in Drug Product Lifecycles and When Such Negotiations Should Occur on Small Molecule and Biologic Drugs

West Health supports expansion of negotiation to improve patient affordability and access while continuing to offer incentives for innovation. Our analyses show that there is significant opportunity to improve the program's performance and integrity by selecting both small molecule and biologic drugs sooner than current law allows, and that policymakers should simultaneously be mindful of the nuances of such policies.

We modeled implementing differing timelines for drug selection for Medicare negotiation under current law (7 years for small molecule drugs and 11 years for biologic drugs), the SMART Prices Act (reduce time to selection to 3 years for both small molecule and biologic drugs), and the EPIC Act (increase time for small molecule drugs from 7 to 11 years to match the current law timeframe for biologic drugs) (see

Table 3).

Reducing the time to selection, as proposed in the SMART Prices Act, increases savings compared to current law by nearly double ($120.5 billion versus $61.7 billion), increases the number of drugs selected for negotiation, and results in higher average savings per drugs ($1.3 billion versus $709 million), as lower prices apply well before drugs are deselected for generic or biosimilar entry (see

Table 3).

Increasing the time to selection for small molecules as proposed under the EPIC Act reduces savings compared to current law ($43.8 billion versus $61.7 billion) and average savings per drug ($654 million versus $709 million) (see

Table 3). Drugs selected under this scenario are closer to generic or biosimilar entry and many have had gross sales reduced due to competition from newer branded products, limiting savings potential.

Table 3. *Projected Outcomes of Altering Time to Selection in Medicare Negotiation (2029-2033)*

	Federal Savings (Billions)	Number of Drugs Selected	Average Savings per Drug Millions ($)
Current Law[a]	$61.7	87	$709
SMART Prices Act[b]	$120.5	95	$1,269
EPIC Act[c]	$43.8	67	$654

Source: West Health–Verdant Research Medicare Negotiation Outcomes Calculator.

Notes: [a] Under current law, small molecule drugs can be selected for Medicare price negotiation 7 years after FDA approval and biologic drugs can be selected 11 years after FDA approval. [b] The SMART Prices Act proposes reducing time to selection to 3 years for both small molecule and biologic drugs. [c] The EPIC Act proposes increasing time for small molecule drugs from 7 to 11 years to match the current law timeframe for biologic drugs.

Reducing time to selection, however, does not always increase savings. For example, our analysis reveals that keeping other parts of current law but changing time to selection to 6 years for both small molecule and biologic drugs result in savings of $110.3 billion (see ***Appendix 1***). While these savings outperform the slower selection timeline of current law, they can be outperformed by slower timing combinations, such as 7 years to selection for biologic drugs and 5 years for small molecule drugs ($113.8 billion).

This effect arises from the relationship established in statute between a drug's time on the market, when it becomes eligible for negotiation, and the level of the offer ceiling applied during negotiation. When they are selected earlier, drugs are more likely to qualify for the lower discounts of the short-monopoly offer ceiling, while waiting to later years to select drugs makes it more likely that they will face the steeper discounts of the extended-monopoly and long-monopoly categories.

This is not to say that earlier selection results in lower savings. A drug selected within a year of launch and renegotiated as it ages into steeper offer ceilings will save more money than capturing savings for this drug only towards the end of its time on the market. But several factors can exaggerate the effect of lower savings from earlier selection and may require a policy or political response.

One factor is that modeling timeframes can curtail the savings contribution of drugs negotiated earlier in their lifecycle. Because many top-spending drugs are on the market for more than a decade without generic or biosimilar competition, even the Congressional Budget Office's 10-year window may not capture the full effect.

Another factor is interaction with other elements of the policy. For example, newer drugs can crowd out or delay selection of older products with consistently high spending levels and lower offer ceilings if they reach higher ranks in gross spending. Reshuffling which drugs get selected on earlier timelines can also mean that some drugs are selected as their spending is already waning. These effects can be offset by policies already identified in the RFI, such as setting a minimum number to negotiate, and/or targeting older products. The

Committee could consider, for example, mandatory negotiation regardless of rank on the spending list after a certain number of years on the market without generic or biosimilar competition.

West Health is pleased to offer any technical assistance the Committee might need to identify and navigate these nuances.

Eliminating the Blockbuster Drug Bailout Included in H.R.1, the 2025 Reconciliation Act, and Replacing it With the No Big Blockbuster Bailouts Act (S. 3019)

West Health supports eliminating exemptions and delays from negotiation for blockbuster drugs with orphan indications. By selecting for drugs with more than $200 million in Medicare spending, the law is inherently designed to negotiate commercially successful products that do not represent the limited market opportunity on which incentives to develop orphan drugs are premised.

Our analysis shows that some of the largest opportunities for improving federal savings come from eliminating the additional orphan drug protections enacted by H.R.1, the 2025 Reconciliation Act ($75.8 billion vs $61.7 billion). We estimate that the No Big Blockbuster Bailouts Act, for which the Committee seeks feedback, would save even more ($80.0 billion) (see 4).

The other policy scenarios we present in Table 4 show the bounds of policymaking around drugs with orphan indications. Limiting negotiation to only those drugs without any orphan indication would lower savings to $52.9 billion, while eliminating any protections saves $80.9 billion.

Table 4. *Projected effects on federal savings of different orphan policies (2029-2033)*

	Federal Savings Billions ($)	Number of Drugs Selected	Number of Small Molecules Drugs Selected (N, % selected)
Current Law[a]	$61.7	87	58 (67%)
No Big Blockbuster Bailouts Act[b]	$80.0	100	64 (64%)
Reverting to IRA[c]	$75.8	100	64 (64%)
Exempting all drugs with any orphan indication	$52.9	76	56 (74%)
Making no exemptions for any drugs with orphan indications	$80.9	100	61 (61%)

Source: West Health–Verdant Research Medicare Negotiation Outcomes Calculator.

Notes: [a] Exempting any pure orphan drug and delaying negotiation to start timeline from first non-orphan approval. [b] Modify current law by removing H.R.1 delay provision and restrict H.R.1 exemption from negotiation to orphan drugs with >$400 million in spending. [c] Exempting any pure orphan drug with only one orphan designation.

The rationale for orphan drug protections breaks down once a drug reaches blockbuster status. Special negotiation exemptions exist to offset slow cost recovery and limited market opportunity – but our analysis, and subsequent research by Verdant Research, shows neither applies to orphan drugs that become blockbusters.

In one study, we found that drugs meeting the spending threshold for negotiation but shielded by orphan provisions were nonetheless costly to the program. Many exceeded $1 billion a year in Medicare spending even under the IRA's narrower original exemption. And because many of these products are still relatively new on the market, manufacturers have time to adjust pipeline strategies specifically to qualify for H.R.1's broader exemptions and delays. Most tellingly, a subsequent study by Verdant Research found no significant difference in time to clinical trial cost recovery between drugs that qualify for IRA exemptions, H.R.1 exemptions, H.R.1 delays, or no special treatment at all.

Preserving and Strengthening the Implementation of Maximum Fair Price at Point of Sale

In addition to the savings that the program has generated in its first years, **West Health believes the application of maximum fair price (MFP) at the point and time of care and the fact that the negotiation does not discriminate between high-spending drugs with high and low net prices is highly important**. This combination of policies has been the first meaningful disruption of the rebate system pharmaceutical companies and supply chain intermediaries claim to hate but to which they are fully beholden. It also has led to changes that benefit patients directly and extend beyond Medicare:

1. Manufacturers lowered list prices for 6 of the first 10 drugs to be negotiated to avoid the complexities and costs of implementation – this extends savings beyond Medicare.
2. Negotiating drugs with high gross to net discounts has the effect of pulling inflationary rebates out of Part D and restores a more functional market in which plan sponsors compete.
3. Three drugs in the first Initial Price Applicability Year (IPAY) cohort are being deselected because of generic entry – it is good if negotiation can hasten the entry of generics and biosimilars to bring down prices.

We believe that further reforms to improve Medicare negotiation should continue this policy combination to break with the long-standing reimbursement traditions that inflate the prices to benefit third parties and supply chain intermediaries' bottom lines at the expense of patients. Pharmacies, Pharmacy Benefit Managers, and providers are critical parts of the supply infrastructure that is required to get patients good access to affordable medicines, and they should be paid according to the value of the services they deliver to patients and the healthcare system. By continuing to effectuate MFP at the point of sale and including drugs with both high and low net prices, the Committee can open the door to payment policies that reduce their dependence on markups and discounts for high-priced drugs and shift towards payments for the valuable services they provide to patients.

To that end, West Health supports the introduction of alternative payment models that supplant incentives to prefer higher-priced drugs by paying supply chain intermediaries and healthcare providers for the value of their services to patients.

Potential New Payment Models for Prescription Drugs

West Health also sees an opportunity for novel payment models to address affordability challenges that traditional per-unit pricing struggles to solve, particularly for drugs used by broad populations and for launch prices that increasingly outpace what patients and payers can sustainably absorb. We offer the following recommendations on two specific approaches raised in the RFI:

- Developing a subscription model to help facilitate access and lower pricing on certain drugs utilized by broad populations, including GLP-1s
- Addressing high launch prices

Developing a Subscription Model to Help Facilitate Access and Lower Pricing on Certain Drugs Utilized by Broad Populations, Including GLP-1s

West Health supports the Committee's interest in innovative financing and access models that can expand appropriate access to GLP-1 therapies while maintaining long-term affordability for patients, payers, and taxpayers. These approaches hold real promise, but significant open questions remain about when they make sense and how to design them for lasting success: all questions we are actively working to answer.

Through the West Health Accelerator at Duke-Margolis, West Health and the Duke-Margolis Institute for Health Policy have engaged Part D plans, state Medicaid agencies, and other stakeholders to evaluate financing approaches for GLP-1 therapies in obesity treatment. A consistent theme across these discussions has been significant uncertainty about future utilization, treatment duration across patient populations, and the resulting budget impact for payers. Uncertainty makes it difficult for payers to assess financial risk and design sustainable payment arrangements.

Closing these evidence gaps is a prerequisite for durable policy in this space, not a side issue. We encourage the Committee to continue supporting research on utilization patterns, treatment duration, and budget impact, and we welcome the opportunity to share Accelerator findings as this evidence base develops, including through direct technical assistance to Committee staff as specific financing proposals take shape.

Addressing High Launch Prices

West Health encourages the Committee to pursue policies that address high launch prices. New drugs continue to be introduced at high and growing price points, regardless of how well they work, and both manufacturers and supply chain and prescribing intermediaries benefit from these high prices. While the economic rewards encourage manufacturers to develop drugs for the US and to introduce them here first, this does not guarantee that patients get the best drugs. In fact, indiscriminately high prices encourage the industry and providers to put financial rewards over patient benefits.

West Health views value-based pricing and payment, both for drugs and the services of those who supply and administer them, as an important tool for future reforms that aim to balance affordability, access, and innovation.

Section II: Enhancing Prescription Drug Affordability

West Health supports the Committee's efforts to identify policies that improve prescription drug affordability for patients. **We believe affordability policies, such as out-of-pocket caps, can play an important role in reducing financial barriers to needed medications, but they are most effective when paired with reforms that address the underlying market dynamics driving high drug prices**. Without efforts to address underlying prescription drug market issues, patient affordability initiatives may simply redistribute costs among patients, payers, employers, and taxpayers.

Lowering Patient Out-of-Pocket Costs

As the Committee considers expanding out-of-pocket caps for prescription drugs, West Health encourages a targeted approach that maximizes patient benefit while minimizing unintended consequences. Evidence suggests that thoughtfully designed out-of-pocket protections can improve access to needed medications while improving patient outcomes. Our research found that reductions in patient out-of-pocket costs decrease cost-related medication nonadherence and decrease negative patient health outcomes. Similarly, Marinacci et al. (2026) found that Medicare beneficiaries experienced a 4.9 percentage point reduction in cost-related medication nonadherence after the Inflation Reduction Act's 2025 prescription drug provisions.[3] However, when selecting drugs beyond insulin for out-of-pocket caps, **we suggest the Committee prioritize drugs where cost-sharing can least be rationalized due to condition severity and lack of therapeutic alternatives or cheaper generics**.

To support the impact of these affordability policies, **West Health strongly encourages pairing these affordability policies with reforms that address the underlying drivers of high drug prices**. We urge the Committee to address underlying prescription drug market issues, such as by strengthening Medicare drug price negotiation, promoting value-based pricing, and reducing supply chain and provider incentives to prescribe higher-priced drugs. We support the Committee's efforts to stabilize Part D premiums alongside out-of-pocket caps, and in general, efforts to use a comprehensive approach to address prescription drug affordability as discussed in Sections I and III.

Addressing Perverse Dynamics in the Supply Chain

Consistent with our strong support of addressing root causes of high drug prices, West Health appreciates the Committee's focus on examining the impact of vertical integration on prescription drug costs. **We support additional research to better understand whether vertical integration in the prescription drug supply chain produces measurable benefits for patients or is primarily producing adverse consequences on costs for consumers and government payers**.

We also support research on solutions to address adverse pricing consequences of vertical integration, including examining state policy approaches that could serve as helpful models for federal policymaking. For example, some states including Arkansas and

[3] Marinacci LX, Mein S, Rome BN, Wadhera RK. Cost-Related Medication Nonadherence After the Inflation Reduction Act. *JAMA Intern Med.* 2026;186(5):609–617. doi:10.1001/jamainternmed.2026.0012

Tennessee have enacted "self-referral" laws that aim to prevent pharmacy benefit managers from operating retail and mail-order pharmacies to avoid conflicts of interest that can lead to increased drug prices.

West Health supports steps like these and sees them as helpful for developing data on whether and how vertically integrated systems raise prices.

West Health is broadly supportive of policies that shift supply chain revenues towards the value of the services they render rather than the drugs and patients they choose. However, such policies are only sustainable if increased dispending/service fees are offset by limits on spread pricing or markups based on a drug's price or cost. We support pairing such reforms with policies that cap reimbursement for the drug itself, such as National Average Drug Acquisition Cost-based benchmarking.

Lastly, **West Health also supports the Committee's interest in increasing transparency and consideration of margins for an entire vertically integrated entity receiving Medicare funding and not just the plans themselves**. We believe it is worth investigating whether CMS could develop a new standard for how margin is considered for vertically integrated sponsors in the Part D bidding process. Such a standard could be a viable and impactful step toward preventing program abuses and putting downward pressure on drug costs in vertically integrated systems.

Section III: Bolstering Biopharmaceutical Innovation in the United States

West Health supports policies that strengthen biopharmaceutical innovation by improving participation in clinical trials. **We encourage policies that address barriers to clinical trial participation among older adults, who remain underrepresented in clinical trials despite bearing a disproportionate burden of chronic disease**. Representative clinical trials generate more complete evidence on the safety, effectiveness, and clinical value of new therapies, providing a stronger foundation for regulatory, coverage, and payment decisions.

Conclusion

West Health appreciates the Committee's continued leadership on prescription drug affordability. The policy options addressed in this response, expanding Medicare's negotiating power, pairing affordability relief with root-cause reform, and strengthening the evidence base for future innovation, represent a meaningful path toward lowering costs for patients without sacrificing the value drugs deliver.

We welcome the opportunity to continue working with the Committee as it develops legislation, including through our modeling tools, original research, and policy analysis. Should Committee staff have questions or wish to discuss any of these recommendations in greater detail, please contact Namrata Uberoi, Executive Director Health Care Cost and Affordability at nuberoi@westhealth.org.

Sincerely,

Timothy Lash
President, Gary and Mary West Foundation
President, West Health Institute
President & Chair, West Health Policy Center

Appendix

Appendix 1. *Federal savings (billions) outcomes of policies altering time to selection (2029-2033), otherwise maintain current law*

		Time to biologic drug selection (years)										
		1	2	3	4	5	6	7	8	9	10	11
Time to small molecule drug selection (years)	1	120.5	120.5	120.5	120.5	119.9	118.4	116.8	113.3	109.8	95.7	80.7
	2	120.5	120.5	120.5	120.5	119.9	118.4	116.8	113.3	109.8	95.7	80.7
	3	120.5	120.5	120.5	120.5	119.9	118.4	116.8	113.3	109.8	95.7	80.7
	4	120.5	120.5	120.5	120.5	119.9	118.4	116.8	113.3	109.8	95.7	80.7
	5	118.1	118.1	118.1	118.1	117.7	115.9	113.8	110.7	107.2	92.9	77.7
	6	112.6	112.6	112.6	112.6	112.1	110.3	108.4	105.5	101.8	86.6	71.1
	7	106.1	106.1	106.1	106.1	105.1	103.3	101.5	97.7	93.8	77.7	61.7
	8	99.5	99.5	99.5	99.5	99.1	97.3	95.5	90.7	86.3	69.9	53.6
	9	90.8	90.8	90.8	90.8	90.2	88.4	86.3	81.1	76.5	60.1	44.1
	10	91.5	91.5	91.5	91.3	90.8	89.1	86.3	81.1	76.4	60.0	44.1
	11	91.8	91.8	91.8	91.6	90.9	88.8	86.0	81.3	76.6	59.7	43.8

Source: West Health–Verdant Research Medicare Negotiation Outcomes Calculator.