The Honorable Ron Wyden
Ranking Member
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

August 17, 2026

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

Dear Senate Finance Committee Ranking Member Ron Wyden and Senate Finance Committee Minority Staff,

On behalf of the California Public Employees' Retirement System (CalPERS) and Covered California, we are writing in response to the Senate Finance Committee Minority Staff's Request for Information on Commonsense Policy Options to Lower Drug Prices for Patients. We strongly support the Committee's efforts to lower drug prices and increase affordability while encouraging biopharmaceutical innovation.

With more than 1.5 million members, CalPERS is the largest purchaser of public employee health benefits in California and the second largest public purchaser in the nation after the federal government. In 2025, we spent over $13.9 billion to purchase health benefits for active and retired members and their families on behalf of the State of California (including the California State University system) and nearly 1,200 public agencies and schools. Approximately 18% of our $13.9 billion spend was for outpatient prescription drugs alone. Covered California, as the nation's largest state-based health insurance marketplace, has provided coverage to over 6.3 million Californians – about one in six residents – since its launch in 2014. Similar to CalPERS, in 2025, approximately 18% of Covered California plans' medical spending went toward prescription drugs.

Prescription drugs play an important role in the health and well-being of our members and their families. Rising drug costs are driven largely by growing utilization and increasing launch prices of specialty drugs and cell and gene therapies. Although specialty medications represented only 1.6% of outpatient pharmacy utilization in 2025, they accounted for 41% of CalPERS outpatient pharmacy spend. While specialty drugs represent a small fraction of drugs prescribed and dispensed to our members, they account for a disproportionately large portion of the overall CalPERS and Covered California qualified health plan (QHP) issuer drug spend. Below we provide specific feedback on your proposed policy areas:

Section I: Lowering Drug Prices
I. Bolstering Medicare's Ability to Negotiate Lower Drug Prices

CalPERS and Covered California support the goals of the Medicare Drug Price Negotiation Program and encourage Congress to extend its benefits to the commercial market to improve affordability across the health care market.

The 2024 Congressional Budget Office (CBO) examined a policy that would extend Medicare-negotiated maximum fair price (MFP) to commercial insurers. CBO found that extending these negotiated prices would lower commercial drug prices, although the overall impact would be initially modest because only ten drugs were included in the first cycle of the Medicare Drug Price Negotiation program.[1] The impact is expected to increase as additional drugs are added over time. Because the program is now entering its third cycle of negotiations, an updated CBO analysis should be conducted to assess the potential effects using the expanded list of negotiated drugs.

One practical approach for extending these savings is a model developed by the National Academy for State Health Policy. Instead of requiring manufacturers to sell at Medicare's MFP, the model uses it as a payment cap.[2] Health plans would not reimburse more than the Medicare price for selected drugs. States could apply this to all regulated commercial plans or only to state employee plans, while Medicaid is excluded because it already receives large statutory rebates. States, such as Vermont and Maryland, use this approach and have identified potential savings, especially for high-cost drugs like GLP-1 therapies and specialty biologics. While results would vary, these analyses show the potential value of using Medicare prices as a benchmark in the commercial market.

Any expansion would require careful design. Commercial drug prices are set through confidential rebates, and actual net prices vary widely. Because these prices are not transparent, it is difficult to fully compare them with Medicare's negotiated prices.[3] Greater transparency would help policymakers better assess the impact of expanding this approach. Additionally, Congress should also consider the tradeoffs. Lower prices could improve affordability for employers, states, and consumers, but could also affect

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[1] *See:* Congressional Budget Office. Alternative Approaches to Reducing Prescription Drug Prices. *Available at:* https://www.cbo.gov/publication/58793
[2] *See:* Jennifer Reck. Extending Medicare Maximum Fair Prices for Drugs to State Markets. *Available at:* https://nashp.org/extending-medicare-maximum-fair-prices-for-drugs-to-state-markets/
[3] *See:* Steven Liberman and Paul Ginsburg. Knowing Actual Prices Will Help HHS Set the Maximum Fair Price Under the Inflation Reduction Act. *Available at:* https://www.healthaffairs.org/content/forefront/knowing-actual-prices-help-hhs-set-maximum-fair-price-under-inflation-reduction-act

manufacturing pricing strategies, rebates, and incentives for future drug development.[4] Congress will need to balance affordability, access, and innovation when evaluating next steps.

In designing any expansion, policymakers should consider not only how drugs are priced, but also which drugs account for the greatest spending in the commercial market. There are other sources of data, including commercial data, available in California's All Payer Claims Databases (APCD) that could be used to inform the list of selected drugs that drive costs in commercial populations, which may differ from that of the Medicare population. Across populations, a small number of drugs account for a large percentage of total drug spend, but the mix of those drugs may differ.[5] For example, Medicare drug costs may be largely driven by a mix of medications for chronic conditions, cancer, and specialty drugs due to its older population, whereas the commercial trend may be driven largely by specialty drugs alone. To illustrate this disparity, the drug with the highest spending among QHP issuers participating with Covered California, as reflected in the California APCD, are: Stelara, Biktarvy, Humira, Skyrizi, and Rinvoq. Four out of these five highest-cost drugs are for rheumatologic conditions and/or inflammatory bowel disease, and one is for human immunodeficiency virus (HIV).

To this end, we strongly recommend that Congress enact policies identical to those proposed by H.R. 6166, the Lowering Drug Costs for American Families Act. In part, this bill builds upon the success of the Inflation Reduction Act by allowing commercial insurers to leverage the Medicare MFP policy and increase the number of drugs eligible for negotiation each year from 20 to 50. The CBO has modeled each of these policy changes and estimated that both policies would yield a one to three percent reduction in average drug prices by 2031.[6]

Factoring International Pricing into Negotiation

We believe the incorporation of international reference pricing into the Medicare Drug Price Negotiation Program could achieve even further savings, as many comparable countries pay significantly less for identical drugs used in the United States, while preserving access to innovative treatments. The CBO estimated that setting a maximum allowed price based on prices outside the United States could result in a more than five

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[4] *See:* Congressional Budget Office. Additional Information About Drug Price Negotiation and CBO's Simulation Model of Drug Development. *Available at:* https://www.cbo.gov/publication/59792

[5] *See*: Juliette Cubanski, Matthew Rae, Katherine Young, and Anthony Damico. How Does Prescription Drug Spending and Use Compare Across Large Employer Plans, Medicare Part D, and Medicaid? *Available at:* https://www.kff.org/medicare/how-does-prescription-drug-spending-and-use-compare-across-large-employer-plans-medicare-part-d-and-medicaid/

[6] *See:* Congressional Budget Office. Alternative Approaches to Reducing Prescription Drug Prices. *Available at: https://www.cbo.gov/publication/58793*

percent reduction in average drug prices.[7] While the international price would not be set as the maximum allowed price in Medicare negotiations, it would allow policymakers to evaluate whether U.S. prices appropriately reflect therapeutic value. Using international benchmarks as one component of negotiations would help ensure that American purchasers and beneficiaries are not consistently paying substantially more than similarly situated countries for the same therapies.

Delivering Lower Negotiated Drug Prices to Patients Faster

CalPERS and Covered California support expanding the volume of drugs the Centers for Medicare and Medicaid Services (CMS) negotiates annually under the Medicare Drug Price Negotiation Program. However, expanding the number of drugs selected annually will yield diminishing returns unless the criteria are also adjusted to reach drugs with meaningful cost impact.

To expand the pool of eligible drugs, we recommend broadening the criteria that determine negotiation eligibility. This could include revising the exclusion timeframes that currently exempt drugs from negotiation for a number of years after approval by the Food and Drug Administration (FDA); nine years for small-molecule drugs and thirteen for biologics. Shortening these timeframes would allow more drugs to qualify for negotiation sooner. Another option is to incorporate additional data sources beyond Medicare claims into the negotiation process, since eligibility and prioritization currently rely on Medicare Part B and Part D spend data. Adding other sources, such as state APCDs, nationally representative commercial claims databases, and national prescription drug spending data, would help identify high-cost drugs that may not rank as high spend under Medicare data alone but still contribute significantly to national drug costs.

We also recommend CMS review entire therapeutic classes of drugs simultaneously, rather than negotiating one drug at a time. For example, instead of negotiating Eliquis or Xarelto separately, CMS could negotiate all direct-acting oral anticoagulants as a single class. This approach shifts negotiating leverage away from manufacturers by treating therapeutically similar drugs together. This approach limits manufacturers' opportunities for abuse, such as brand-to-brand switching within the same category, that would otherwise preserve a class's overall cost. Negotiating by class also better aligns payment policy with clinical practice, where prescribers often choose among multiple options within the same therapeutic class.

II. Enhancing Manufacturer Accountability for Price Gouging

[7] *Ibid.*

CalPERS and Covered California recommend extending the Medicare Inflation Rebate Program to the commercial market to build on the savings already achieved and further discourage manufacturer price increases. According to Price Waterhouse Coopers (PwC) 2027 Medical Cost Trend report, commercial pharmacy costs continue to outpace commercial medical costs, and the rapid adoption of high-cost therapies is contributing to health care spending growth. PwC recommends prioritizing governance of high-cost drug classes and medical benefit therapies within the next plan year. Network design and reimbursement remain the most critical levers over the long-term for resetting the cost baseline.[8]

Other research has found that if a similar Part D Inflation Rebate Program policy were extended to the commercial market, it could generate up to $8.1 billion in savings in 2021 alone by imposing rebates on 1,100 drugs. To reduce the administrative burden of extending Medicare's rebate infrastructure to the commercial market, the same study found that eligibility could be limited to a smaller set of high-cost drugs, such as those ranked in the top 300 by total spend or priced above $830 per month. This narrower approach would reduce the number of drugs requiring evaluation by half while still capturing 85 to 96 percent of the total estimated savings.[9]

We believe the adoption of this policy would directly benefit commercially insured individuals through reduced out-of-pocket spending and increased access. Again, we urge you to enact the provisions in the Lowering Drug Costs for American Families Act that extend this rebate program to the commercial market.

III. Potential New Payment Models for Prescription Drugs

Subscription Models

CalPERS and Covered California recognize that subscription models may improve access to certain high-cost medications while providing greater budget predictability for purchasers. GLP-1 medications are among the most significant emerging cost drivers in the commercial market. In 2024, CalPERS non-Medicare members utilized nearly 193,000 30-day prescriptions for Ozempic, Rybelsus, and Wegovy alone, highlighting both the growing demand for these therapies and the importance of developing sustainable payment approaches.

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[8] *See:* Price Waterhouse Coopers. Five forces. Few brakes. What 2027 means for healthcare costs. *Available at:* https://www.pwc.com/us/en/industries/health-industries/library/assets/pwc-behind-the-numbers-2027.pdf

[9] *See*: Marissa B. Reitsma, Stacie B. Dusetzina, Jeromie M. Ballreich, Antonio J. Trujillo, and Michelle M. Mello. Estimated Savings from Extending Prescription Drug Inflationary Rebates to All Commercial Plans. *Available at:* https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2024.00724

At the same time, GLP-1 medications differ in important ways from the hepatitis C treatments and antibiotics that have been the focus of existing subscription models implemented by government entities. Those models were designed to address specific market challenges, such as expanding access to curative hepatitis C treatments or encouraging antibiotic innovation despite stewardship-driven low utilization. In contrast, GLP-1 medications are most effective when used on a long-term basis, the eligible population may continue to grow, and market prices may change as new competitors enter the market and federal drug pricing policies evolve. As a result, it may be more challenging to establish a fixed payment arrangement that remains appropriate for both purchasers and manufacturers over time. We therefore offer the following considerations regarding the proposed model.

Should there be separate subscription models for government health programs (e.g., Medicare, Medicaid) and private markets (e.g., commercial, employer)?

We support allowing distinct subscription models for public and private purchasers since these markets operate under different statutory authorities, benefit structures, financing arrangements and procurement requirements. However, we believe separate models should share common core components, such as standardized reporting, outcomes measurement, transparency requirements, audit rights, and performance accountability, to reduce administrative complexity and facilitate broader adoption.

While we support new payment models for drugs such as GLP-1s, we also encourage consideration of how new pricing models may affect individuals who are already receiving GLP-1 drugs through existing coverage. A recent New England Journal of Medicine perspective article projects that introducing a new pricing model outside existing structures could increase overall government spending by making GLP-1s more affordable for people not currently taking them, while doing nothing to lower prices or out-of-pocket costs for members who already receive them through existing coverage.[10]

Should participation in such models be mandatory for plans? Why or why not?

Participation should remain voluntary so purchasers can select the approach that best meets the needs of their covered populations. A mandatory model could limit innovation and prevent plans from pursuing alternative approaches that may generate greater value. CMS should establish a framework that encourages participation through demonstrated value and predictable savings.

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[10] *See:* Stacie B. Dusetzina. Access to GLP-1s for Medicare Beneficiaries — A Bridge to Nowhere? *Available at:* https://www.nejm.org/doi/full/10.1056/NEJMp2605694?query=TOC

How should these models be funded? If Senate Democrats were to consider member-weighted assessments on plans as a funding mechanism, what would the financial impact be on health plans?

Rather than support a broad member-weighted assessment that would require plans with relatively low GLP-1 utilization to subsidize populations with higher utilization, instead we recommend a financing approach that:

1. Reflects actual or projected utilization and clinical need;
2. Preserves incentives for appropriate prescribing;
3. Maintains budget predictability for purchasers;
4. Uses transparent methodologies to determine subscription payments; and
5. Links payments to specified outcomes.

The core challenge is managing broad population-level budget exposure while ensuring that real-world value depends on appropriate patient selection, medication adherence, and patient outcomes over time. Any subscription or capped-spend arrangement should be coupled with an outcomes-based payment structure and clear clinical guardrails.

For example, if eligible members do not achieve agreed-upon real-world benchmarks, such as clinically meaningful weight loss or expected treatment persistence, manufacturers could be held financially liable to purchasers in the form of rebates. This approach would better align incentives and help ensure that spending is directed toward clinically appropriate use.

What GLP-1 indications should be covered under such models?

Subscription models should prioritize indications supported by robust clinical evidence and demonstrated value to patients and purchasers. Models should include FDA-approved indications with well-established clinical benefits, including obesity.

On what cycle and under what circumstances should model agreements with manufacturers be renegotiated (e.g., new market entrants/technologies, new indications, new clinical and safety data)?

Subscription agreements should aim to provide sufficient stability to facilitate long-term budgeting while allowing periodic reassessment. CalPERS and Covered California would likely support agreements lasting approximately three to five years, with annual performance reviews and opportunities for renegotiation when:

- Significant new clinical evidence emerges;
- New competitors or biosimilars enter the market;
- FDA-approved indications materially expand;

- Utilization differs substantially from projections; or
- Changes to Medicare pricing policies materially affect market dynamics.

This approach would balance budget predictability with flexibility to respond to evolving market conditions.

What other types of drugs beyond GLP-1s could be good candidates for subscription models and why?

Potential future candidates could include certain specialty biologics or gene therapies. However, each therapeutic class should be evaluated independently rather than through a one-size-fits-all approach. Gene therapies are typically administered as one-time treatments rather than the chronic ongoing therapy GLP-1s represent. The underlying challenge is about smoothing a large upfront cost rather than recurring utilization and uncertain long-term effect. Subscription models may be appropriate for high-cost therapeutic classes when:

- Spending is concentrated among a relatively small number of products;
- Demand is reasonably predictable;
- Clinical outcomes can be measured;
- Traditional rebate arrangements have not adequately controlled costs; and
- Manufacturers possess sufficient market power to justify alternative purchasing arrangements.

With respect to Medicare, how should any new subscription model interact with the Medicare Drug Price Negotiation Program?

Any subscription model should complement existing Medicare Drug Price Negotiation policies rather than duplicate or weaken them. The interaction between these policies should maximize beneficiary access while strengthening Medicare's ability to obtain sustainable value. CMS should ensure that:

- Negotiated MFPs remain the foundation for Medicare pricing where applicable, and any subscription price should be at or below the applicable MFP;
- Subscription arrangements generate savings beyond those achieved through negotiated prices alone;
- Manufacturers cannot use subscription agreements to circumvent negotiated pricing requirements; and
- Payment methodologies remain transparent to preserve confidence in both programs.

Addressing Launch Prices

CalPERS and Covered California recognize the importance of maintaining incentives for pharmaceutical innovation. However, sustainable innovation depends on a health care system in which purchasers can continue to afford breakthrough therapies. Rising drug costs are driven largely by the growing utilization and increasing launch prices of specialty drugs and cell and gene therapies. While specialty drugs represent a small fraction of drugs prescribed and dispensed to our members, they account for a disproportionately large portion of the overall CalPERS and Covered California QHP issuer spend.

We believe a drug's launch price should reflect its clinical value and expected benefit to patients. We support the Institute for Clinical and Economic Review's (ICER) approach to assessing whether launch prices are cost-effective and aligned with the value a drug provides.[11] This challenge is particularly significant for specialty medications, where high prices can create substantial affordability challenges even when utilization is relatively limited. For example, several oncology therapies used by CalPERS members exceed $13,000 to $25,000 per 30-day supply. These costs can place considerable financial pressure on patients, health plans, and purchasers.

ICER's framework evaluates the net health benefit of the new treatment relative to existing standards of care and considers whether the price is reasonable relative to the additional benefit provided. In practical terms, it helps determine whether the amount paid for a therapy is proportionate to the health benefits it delivers.

Effective pricing policies should reward meaningful therapeutic advances while discouraging pricing practices that are not supported by demonstrated improvements in clinical outcomes. Policymakers should refine pricing methodologies to recognize high-value innovation while promoting competition and ensuring responsible stewardship of public and private health care resources.

Section II: Enhancing Prescription Drug Affordability

I. Lowering Patients Out-of-Pocket (OOP) Costs

OOP Caps

CalPERS and Covered California recognize that OOP costs for chronic care medications can reduce medication adherence or cause patients to delay or forgo treatment, ultimately worsening patient outcomes. Because of this, we each offer benefit

[11] *See:* Foluso Agboola and Sarah K Emond. ICER's launch price and access report: 5 key takeaways and 5 questions we should all be asking. *Available at:* https://pmc.ncbi.nlm.nih.gov/articles/PMC13032863/

designs with low or zero OOP expenditures for many chronic conditions. In addition, we support benefit designs that provide clear OOP maximums to protect consumers from undue financial hardship. However, we do not believe applying separate caps to OOP drug costs is the optimal strategy for addressing the issue of high and rising drug costs, particularly for high-cost chronic care medications. While OOP caps reduce the financial burden on patients, they do not address the underlying problem, namely, the high price of the drug. If OOP caps are imposed without addressing the high price of the drug, the resulting effect is to shift costs rather than lower them. OOP caps increase utilization of high-cost drugs, benefiting drug manufacturers while shifting the costs of the drugs to plans, purchasers, taxpayers, and ultimately members through higher premiums. Additionally, plans and pharmacy benefit managers (PBM) may respond through formulary changes, tighter utilization management, or other benefit design adjustments that can create new access challenges for consumers.

For these reasons, we recommend that policymakers focus on strategies that directly address the price that manufacturers charge for chronic care medications, including stronger price negotiation applied more broadly to classes of drugs, price regulations, and other reforms that lower total spending rather than merely shifting costs. In prioritizing these efforts, we recommend focusing on drug classes and conditions where the medications are widely used and are associated with substantial member cost burden. This includes drugs used to treat diabetes and obesity, including GLP-1s and certain DPP-4 medications, direct-acting antivirals for hepatitis C, and high-cost autoimmune specialty drugs.

Distortions in Coinsurance and Deductibles

CalPERS benefit design predominantly consists of fixed copayments because they offer a predictable and affordable cost-sharing structure for members.[12] Recent research has found that higher copayments are associated with worse medication adherence, reduced treatment persistence, and increased rates of discontinuation.[13]

Using drug prices to determine member cost sharing, whether based on list prices or net prices, can undermine that predictability. Net prices reflect post-rebate and other manufacturer payments that are often not known at the point of sale and may change throughout the plan year as financial reconciliations occur. As a result, a member's cost-sharing obligation could fluctuate even when their prescription, dosage, and pharmacy remain unchanged.

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[12] *See:* CalPERS. 2026 Health Benefit Summary. *Available at:* https://www.CalPERS.ca.gov/documents/2026-health-benefit-summary/download?inline

[13] *See:* Fusco, Sils, Graff, Kistler, and Ruiz. Cost-sharing and adherence, clinical outcomes, health care utilization, and costs: A systematic literature review. *Available at:* https://www.jmcp.org/doi/10.18553/jmcp.2022.21270

Because net prices are not transparent to members and may vary over time, they are an unstable basis for determining cost sharing. For that reason, we recommend that Congress completely delink cost sharing from drug prices altogether and instead implement the use of fixed copayments. Fixed copayments provide greater predictability, protect members from price volatility, and support access to needed medications.

Generic Drug Price Markups

We agree that the National Average Drug Acquisition Cost (NADAC) can serve as a more useful and more transparent benchmark for generic drug acquisition costs. CalPERS' current PBM incorporates NADAC, along with Average Wholesale Price (AWP) and Wholesale Acquisition Cost (WAC), as pricing benchmarks for oversight and transparency measures. The PBM is required to provide these values when proposing formulary changes and reporting on covered drugs. CalPERS uses these pricing benchmarks to evaluate the clinical, financial, and member impacts of formulary decisions; however, our contract does not require prescription drug reimbursements to be based on NADAC data.

Given the utility of NADAC, we support its use in efforts to address inflated generic drug pricing. A NADAC-based benchmark, with an appropriate dispensing fee, could help align reimbursement more closely with pharmacy acquisition costs and reduce excessive payments for generic drugs. This approach would promote greater transparency, consistency, and stewardship of public and purchaser resources. It would also help ensure savings are not captured unnecessarily by intermediaries in the prescription drug supply chain, without compromising beneficiary access to needed medications.

II. Addressing Perverse Dynamics in the Supply Chain

PBM Gag Clauses

CalPERS and Covered California believe prohibiting gag clauses is an important step towards transparency, but Congress should go further by regulating or prohibiting contract terms that restrict communication between PBMs, purchasers, and manufacturers. In particular, 'exclusive negotiator' and 'non-solicitation' clauses may limit competition by preventing purchasers from exploring alternative pricing arrangements or manufacturers from offering discounts directly to health plans. These restrictions can interfere with fiduciaries' ability to negotiate lower drug prices and may inhibit innovative contracting approaches that could better serve plan sponsors and beneficiaries.

Congress should consider establishing requirements on PBMs to provide their clients with clear and unrestricted data access and prohibit data sharing restrictions. This would effectively allow fiduciaries to negotiate prices while retaining meaningful access to pricing information and the ability to engage directly with manufacturers where appropriate. At the same time, it would preserve necessary confidentiality protections for proprietary pricing data.

Increasing PBM Accountability for Rising Drug Costs

As part of our commitment to prescription drug affordability, CalPERS recently entered into a new PBM contract designed to better align incentives for cost control and member health outcomes. Under this contract, the PBM has agreed to put $250 million at-risk over the five-year contract term if it fails to meet goals for controlling pharmacy benefit costs and ensuring clinical quality outcomes for our members.[14] The contract builds on a shared risk model that CalPERS implemented in its self-funded Preferred Provider Organization contracts with Blue Shield of California (Blue Shield) and Included Health that took effect in 2025.[15] These contracts incentivize total cost accountability and attention to quality by setting performance guarantees. Blue Shield and Included Health agreed to put $100 million at-risk for each of the five years of the contract if they do not meet these guarantees. These experiences have informed our federal policy recommendations in several ways.

To contain prescription drug spending growth, PBM contracts should include meaningful performance accountability, tying financial consequences, such as penalty provisions, directly to whether cost trends and quality goals are met. This approach encourages cost effectiveness, rather than allowing arrangements that leave the PBM with no financial alignment with plan sponsors.

Congress should also consider imposing on self-funded PBMs, and likely on Third Party Administrators providing broader health services, an obligation to meet either a cost-trend or total cost of care target and pay to the plan sponsor a “penalty” to the extent that target is not met. Crafting such a provision would entail addressing a range of substantive and necessary issues, including: (1) setting the trend or total cost target; (2) establishing a clear process for adjusting the target; (3) protecting against the PBM engaging in inappropriate conduct to meet targets (e.g., changing benefits, formulary or

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[14] *See:* CalPERS. CalPERS Announces New Pharmacy Benefits Contract with CVS Caremark to Foster Affordability and Improve Quality. *Available at*: https://www.calpers.ca.gov/newsroom/calpers-news/2025/calpers-announces-new-pharmacy-benefits-contract-with-cvs-caremark-to-foster-affordability-and-improve-quality

[15] *See:* CalPERS. CalPERS’ New Total Cost of Care Guarantee Terms in PPO Contracts Aligns Incentives to Lower Health Care Trend. *Available at:* https://www.calpers.ca.gov/calpers-new-total-cost-of-care-ppo-contract-terms-incentive-lower-health-care-cost

prior authorization practices); (4) protecting plan sponsors from PBMs increasing their administrative fee to offset any potential penalty; and (5) setting a cap and proportional payment structure for any penalty. While hardly simple, such a mechanism would bring financial alignment to the commercial sector for the first time, through which the majority of Americans with employer-sponsored coverage receive their health care.

Congress should enact legislation requiring PBMs to act as fiduciaries, thereby requiring them to act in the best interest of the plan sponsor and its members; require full transparency around compensation and rebates; and prohibit conflicts of interest that could compromise that duty. These obligations should also extend to affiliate disclosure requirements to create a coherent standard for transparency. In addition, building on the Consolidated Appropriations Act (CAA) 2026, PBM arrangements should further be structured to require the lowest net cost across mail order, specialty, and biosimilar drugs, and include transparent, full pass-through rebate arrangements and preferences for lower-cost biosimilar options where clinically appropriate. Purchasers need full access to the financial and clinical data necessary to manage their plans effectively; this must include claims-level data and formulary decision rationale. Finally, federal regulators should ensure that the CAA 2026 audit provisions are implemented though regulations that apply not only to the PBM but also to any entities affiliated with the PBM, such as rebate aggregators and group purchasing organizations (GPOs).

Games & Abuses Due To Vertical Integration

CalPERS and Covered California support CMS developing standards to evaluate profits, margins, and other financial arrangements across vertically integrated organizations participating in Medicare Part D. Traditional plan-level bid review may not capture the full economics of a Part D contract when a health plan, PBM, specialty pharmacy, mail-order pharmacy, or other affiliated entity operates under common ownership or control. Financial arrangements between affiliated entities can shift revenue and expenses across the enterprise, potentially obscuring the true cost of providing the benefit. The Federal Trade Commission has identified significant concerns associated with vertical integration, including incentives to steer patients to affiliated pharmacies, including mail and specialty, and evidence that affiliated specialty pharmacies generated $7.3 billion in dispensing revenue above estimated acquisition costs for certain specialty generic drugs between 2017 and 2022.[16]

CalPERS recommends that CMS require vertically integrated organizations participating in Part D to provide sufficient ownership-level financial information to identify differences

[16] *See*: The Federal Trade Commission. Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers. *Available at*: https://www.ftc.gov/reports/specialty-generic-drugs-growing-profit-center-vertically-integrated-pharmacy-benefit-managers

between the profits reported in the bid and the profits realized across all affiliated entities. CMS should examine PBM administrative fees, spread pricing, rebate retention, affiliated pharmacy reimbursement, and other material transfers of value, using market-based benchmarks and comparisons with unaffiliated entities. CMS should also consider whether vertically integrated financial arrangements are associated with higher beneficiary cost sharing or other outcomes that undermine the value of negotiated savings. Such evaluations would allow CMS to identify potential negative impacts of vertical integration and ensure that any resulting efficiencies benefit beneficiaries rather than being retained by the organizations.

Addressing Price-Linked Compensation

Price-linked incentives beyond PBM reimbursement can include administrative and service fees for GPOs calculated as a percentage of drug spending, pharmacy reimbursement formulas tied to benchmarks such as AWP or WAC, and other payments that increase as the underlying drug price increases.[17,18] CMS should prioritize compensation models that reward value, efficiency, and lower net cost, rather than the gross price of a drug. We recommend Congress advance legislation, such as S. 3751, the Prescription Drug Supply Chain Pricing Transparency Act, which requires the Government Accountability Office to study compensation and payment structures related to a prescription drug's price throughout the retail prescription drug supply chain and determine whether such arrangements create conflicts of interest that could favor formulary selection, distribution, or purchasing of higher-priced drugs.

Section III. Bolstering Biopharmaceutical Innovation in the United States

I. Enhancing Investments in Drug Research & Development

Congress should develop new incentives for non-profit and private sector entities to build or use therapeutic accelerators that translate promising basic research into commercialized medicine. The California Institute for Regenerative Medicine (CIRM) offers a useful model: project teams prioritize affordability and build it directly into their project development rather than as a post-approval afterthought. CIRM first addresses pricing, reimbursement, manufacturing, and patient access, as therapies advance, which helps ensure that promising scientific advances are realistically positioned to reach patients. This approach supports cutting-edge innovation while also helping align breakthrough innovation with a feasible path for Californians, especially underserved

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[17] *See*: FTC. Complaint vs PBM Group Purchasing Organizations. *Available at*: https://www.ftc.gov/system/files/ftc_gov/pdf/d9437_caremark_rx_zinc_health_services_et_al_part_3_complaint_public_redacted.pdf

[18] *See:* Congressional Research Service. Medicare Part D Prescription Drug Benefit. *Available at*: https://www.congress.gov/crs-product/R40611

populations, to better receive and afford the therapies CIRM helps bring forward.[19] We recommend Congress establish a similar program that prioritizes pricing and affordability planning early in the research and development process.

Generally, when it comes to fostering innovation in the health care system, we endorse a principle similar to ICER's; that paying for value helps support and reward innovation that provides meaningful improvements in patient outcomes. As noted above, we believe CMS should prioritize innovation that rewards value, efficiency and lower net cost. Conversely, we should avoid paying or overpaying for services or medications that don't provide additional improvements in outcomes.

We thank you for your consideration and we welcome the opportunity to work with you on our shared goal of lowering prescription drug costs for patients. Please do not hesitate to contact Julia Logan, CalPERS Chief Clinical Director, at (916) 795-0404, Danny Brown, Chief of the CalPERS Legislative Affairs Division, at (916) 795-2565, Monica Soni, Covered California's Chief Medical Officer, at (916) 954-3225, or Kelly Green, Covered California's Director of External Affairs and Community Engagement, at (916) 228-8309, if we can be of any assistance.

Sincerely,

Marcie Frost
Chief Executive Officer

Jessica Altman
Executive Director

[19] *See:* CIRM Accessibility and Affordability Working Group materials, April 30 and June 26, 2025. *Available at:* https://www.cirm.ca.gov/wp-content/uploads/2025/04/AAWG-043025-Final-Post-Binder.pdf and https://www.cirm.ca.gov/wp-content/uploads/2025/06/16.-250626-AAWG-Update-for-ICOC-Presentation.pdf