CONSUMER CHOICE CENTER

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Comments of the Consumer Choice Center

Senate Finance Committee Minority Staff Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients

The Consumer Choice Center appreciates the opportunity to respond to the Senate Finance Committee Minority Staff's Request for Information on lowering prescription drug costs.

CCC is a nonpartisan consumer advocacy group. We advocate for policies that expand consumer choice, lower the prices consumers actually pay, and protect the innovation that produces tomorrow's medicines. We take no position on partisan questions. We do take a position on who ends up paying.

We share the Committee's goal. American patients should not have to navigate a system in which opaque rebates, institutional markups, vertically integrated middlemen, and government payment rules make it nearly impossible to know who pays what. Nor should a patient have to wonder whether a discount created in their name ever reached them.

Congress should distinguish between lowering a price recorded somewhere in the supply chain and lowering the price a patient actually experiences.

These are not the same thing. A great deal of what is marketed as drug pricing reform accomplishes the first and leaves the second untouched. Money moves between manufacturers, wholesalers, pharmacy benefit managers, hospitals, and plans. The patient at the counter sees no change.

That test should be applied to every proposal in this RFI. It should also be applied to programs that already exist.

Debate over drug affordability tends to begin and end with manufacturers. That framing misdescribes the American supply chain.

List prices and net prices in the United States have diverged for years. A substantial share of the difference is absorbed by intermediaries.

Formulary placement can favor a higher-priced product over a cheaper therapeutic equivalent because the higher-priced product generates a larger rebate. Patients whose cost-sharing is calculated on list price then pay more for the privilege. Independent pharmacies face reimbursement terms set by competitors.

CCC therefore urges the Committee to prioritize the following:

1. **Delink PBM compensation from list price.**

2. **Require full pass-through and full disclosure of rebates.**
3. **Ban spread pricing in publicly funded coverage.**
4. **Prohibit rebate walls that block biosimilars and generics.**
5. **Extend transparency to affiliated pharmacy steering.**

Every one of these reforms lowers costs by improving competition. None requires the government to set a price.

340B has become too large

The RFI asks whether mandatory discounts owed by biosimilar manufacturers under government programs, including 340B, should be modified to strengthen the biosimilar market. That is a fair question. Congress should examine the broader incentive structure surrounding 340B at the same time.

HRSA reported that covered entities purchased roughly **$100 billion in outpatient drugs through 340B in calendar year 2025**, an increase of about 23 percent over 2024. Among federally funded programs, 340B drug spending is now second in size only to Medicare Part D.

That should matter to lawmakers concerned about drug costs. It should matter just as much to lawmakers concerned about consolidation.

The original purpose of 340B is worthy. Safety-net providers should be able to stretch limited resources for vulnerable patients. The problem is that the link between the discount and the patient has become very hard to see. A hospital receiving a large statutory discount has not thereby demonstrated that any patient received cheaper medicine or more charity care.

Congress should pursue the following reforms:

1. **Require meaningful 340B transparency.**
2. **Create a clear patient-benefit standard.** Congress should examine mechanisms that let eligible patients share directly in 340B savings at the pharmacy counter.
3. **Strengthen safeguards against duplicate discounts and diversion.**
4. **Ensure 340B does not discourage biosimilar competition.**
5. **Bring contract-pharmacy arrangements into the sunlight.**

Rebate model pilot

CCC has argued that the traditional retrospective 340B structure creates avoidable uncertainty. It is often unclear whether a given prescription qualified for the discount, or whether another mandatory rebate has already been assessed against the same prescription.

Since the RFI was issued, HRSA has announced a revised 340B Rebate Model Pilot Program. It allows qualifying manufacturers to effectuate the statutory ceiling price through a rebate mechanism for a limited set of drugs.

Congress should monitor this pilot closely. A well-designed rebate model could provide claims-level verification before the discount is transferred.

The objective is not to weaken safety-net providers. The objective is to make a $100 billion program easier to audit, harder to game, and more clearly connected to the patients Congress intended to help.

Let patients see the discount at the counter

The RFI correctly raises the problem of cost-sharing calculated on prices that bear little relationship to the net amount a plan ultimately pays.

From a consumer perspective the principle is simple. **Where a substantial discount exists, a patient should not be charged coinsurance calculated as though it does not.**

Congress should require patient cost-sharing to track actual net cost more closely.

The same principle should govern 340B. If a prescription generates a large statutory discount because it was dispensed under a program built for vulnerable patients, policymakers should ask why the eligible patient cannot see a meaningful share of that benefit directly.

Transparency without patient benefit is not enough. Discounts without accountability are not enough. Moving money from one institution to another while patients keep paying inflated out-of-pocket costs is not drug pricing reform.

Do not import foreign price controls

The RFI also seeks input on incorporating international prices into Medicare negotiation. CCC urges Congress not to take this path.

Tying American reimbursement to prices set by foreign governments does not create a competitive market. It imports the output of foreign price-setting systems into the United States. The reference price is not a market signal. It is another government's budget decision.

The underlying complaint is legitimate. Wealthy countries with the capacity to pay more for medicines use monopsony purchasing power to pay less, and American consumers cover a disproportionate share of global research costs. The remedy is trade policy that presses allied governments to pay their share.

The tradeoff should not be waved away. CBO has concluded that reductions in manufacturers' expected revenues reduce the profitability of pharmaceutical research and development, and that depending on the size of those reductions, fewer new medicines are eventually developed and introduced. Fewer medicines is a cost too, and it falls on patients who never learn what they did not get.

This is not a hypothetical concern for the United States. The Foundation for Research on Equal Opportunity found that the United States fell from fourth to eleventh in its World Index of Healthcare Innovation, with a partial recovery to seventh in the 2024 index. The country still ranks first in science and technology and last among indexed nations in fiscal sustainability. American leadership in biotech development is the country's distinctive advantage in healthcare. It is also the asset most easily spent down by policies that look free in the first budget window.

The better route is competition. That means faster approval of generics and biosimilars, prompt issuance of biosimilar billing codes, removal of unnecessary entry barriers, action against anticompetitive contracting and patent thickets, real price transparency, and elimination of supply-chain compensation that rewards higher prices.

Real fixes

Before adding new mandatory discounts or expanding price setting, Congress should address the problems the current program has already created.

1. A single price ignores differences in value. Once a drug is selected, Medicare sets one price regardless of how many conditions it treats or how much benefit it delivers in each. There is no room for indication-based pricing. That flattening discourages investment in additional indications after approval, which is where a large share of a medicine's eventual patient value is discovered.

2. Selection is sweeping in drugs about to face competition. Applying negotiated prices to products on the cusp of generic or biosimilar entry does not reflect the statute's purpose. It substitutes an administered price for competition that was already arriving, and it dampens the incentive to develop the competing product.

3. CMS is redefining what counts as a distinct drug. CMS has proposed treating a subcutaneous product containing an additional active ingredient as the same qualifying single-source drug as the original intravenous biologic. That change would collapse products that the FDA has already determined to be distinct, each with its own application and clinical program. It would also penalize exactly the kind of post-approval improvement that reduces infusion time, reduces clinic visits, and lowers total cost of care. CCC has filed separate comments opposing that proposal, and we urge the Committee to examine whether CMS has the statutory authority to make it.

Each of these is a design problem rather than an inevitability. Congress can correct them without abandoning the goal of affordability.

Conclusion

The RFI correctly identifies distorted incentives across the pharmaceutical supply chain. Congress should build on that insight rather than reach for the simpler instrument of price setting.

For 340B, Congress should insist on an answer to a basic question. A program responsible for $100 billion in annual drug purchases should be able to show where its savings go.

Before creating additional mandatory discounts, expanding price controls, or adding new layers of regulation, Congress should make the discounts that already exist accountable to the patients they were meant to serve.

Lower drug costs should mean lower costs **for patients**.

Respectfully submitted,

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Further reading: Consumer Choice Center on these issues

The positions above are developed at greater length in the following CCC commentary.

- 340B Drug Discount Program: Meant for the Poor but Benefitting Hospitals (Consumer Choice Center, February 2026). On retrospective verification, duplicate discounts, and why the discount so often stops short of the patient.
- Hospital Price Transparency Is a Missing Link in the Healthcare Affordability Debate (Consumer Choice Center, January 2026). On why affordability is a commercial insurance problem as well as a government program problem.
- When Price Controls Backfire: The "Most Favored Nation" Mistake (Consumer Choice Center). On why international reference pricing targets what government pays rather than what patients pay.
- Both Parties Can Work Together to Lower Drug Prices (Consumer Choice Center). On PBM incentives and supply-chain transparency as common ground.
- Fred Roeder, We Can't Subsidize Every Rx While Leading the World in Innovation (RealClearMarkets, January 19, 2026). On the FREOPP rankings, post-approval research, and the cost of a single negotiated price across multiple indications.