



September 28, 2026

Ron Wyden
U.S. Senate
221 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Re: Request for Information: Health Coverage That Works for Everyone

Dear Senator Wyden:

Aimed Alliance is a non-profit health policy organization that seeks to protect and enhance the rights of health care consumers and providers. Aimed Alliance appreciates the opportunity to comment on the request for information: *Health Coverage That Works for Everyone*.

I. Enforcing the 2023 District Court Decision Prohibiting the Use of Copay Accumulators Directly Improves Affordability for Consumers

When patients cannot afford their medications, they may rely on financial assistance from pharmaceutical manufacturers and other third parties to meet their health plan's cost-sharing responsibilities and fill their prescriptions. This financial assistance typically counts toward the health plan's deductible or maximum out-of-pocket limit unless the health plan has implemented a copay accumulator program. Copay accumulator programs exclude the value of third-party financial assistance from counting toward the health plan's deductible or maximum out-of-pocket limit. As a result, consumers have to pay twice to access their medication and reach their annual cost-sharing requirements.

In 2022, the HIV + Hepatitis Policy Institute, a patient advocacy group, filed a lawsuit against the Department of Health and Human Services (HHS) alleging the 2021 Notice of Benefit and Payment Parameters (NBPP) illegally permitted the use of copay accumulators.¹ The District Court agreed with the patient advocacy organization and struck down the 2021 NBPP, reinstating the 2020 NBPP as governing law.² Under the 2020 NBPP, copay accumulators are prohibited unless used for a brand-name medication that has a medically appropriate generic alternative available. Despite the federal ban on copay accumulators, a 2026 report by The AIDS Institute found that in 31 states, health plans are still using copay accumulators in violation of federal law.³ Aimed Alliance urges Congress to require HHS to enforce the 2020 NBPP ban on

¹ HIV + Hepatitis Policy Institute, *Copay Accumulator Litigation*, <https://hivhep.org/copay-accumulator-litigation/>.

² *Id.*

³ The AIDS Institute, *Shortchanged: The Patient Impact of Copay Accumulator Policies in 2026*, https://theaidsinstitute.org/media/documents/02-27-2026-09-23-55-TAI_2026_Report_final.pdf.

copay accumulators and ensure consumers can fully benefit from their copay assistance counting toward their cost-sharing requirements.

II. Require Plans to Clearly Disclose Utilization Management and Third-Party Programs at Open Enrollment

Aimed Alliance applauds the report's recognition that health insurance enrollment should be a simplified process that provides consumers with the information they need to make informed decisions about the type of coverage that best fits them and their families. A key part of this decision is the cost-sharing and utilization management policies they will face for necessary prescription drugs. To ensure consumers are adequately informed at open enrollment, Aimed Alliance urges Congress to require health plans to clearly and conspicuously disclose at open enrollment the utilization management policies, clinical criteria, and cost-sharing programs, like copay accumulators, for all covered prescription drugs.

Consumers with complex and chronic conditions carefully review their formularies at open enrollment to ensure their prescription drugs are covered. However, the formularies do not often include whether the drugs are subject to utilization management policies, quantity limits, or other plan restrictions. As such, Aimed Alliance urges Congress to require health plans to disclose at open enrollment the utilization management policies and associated clinical criteria that apply to prescription drugs.

Similarly, plans do not clearly disclose programs that affect consumers' cost-sharing, such as copay accumulators, maximizers, and alternative funding programs.⁴ Often, consumers only learn of their health plan's partnership with a third-party program when they try to access their medication at the beginning of the plan year. At this point, consumers are told they must work with third-party programs to enroll in copay assistance programs, patient assistance programs, or international pharmacy programs. If consumers refuse to work with the third party and enroll in one of these programs, they face increased cost-sharing requirements that do not count toward their deductible and annual out-of-pocket limits. For many, these programs substantially deviate from how their plan has always worked, leaving consumers facing serious financial burdens to access their medications. Moreover, these programs are often not clearly disclosed in plan documents and may appear as footnotes or under different program names, making them difficult for the average consumer to identify and understand. In some cases, these programs are not even disclosed in plan documents.

When consumers discover these programs after open enrollment, they lose the opportunity to switch plans and must work with these third-party programs to access their covered medications. This is particularly frustrating for many consumers with complex and chronic conditions who

⁴ Aimed Alliance reiterates its long-standing position that copay accumulators are inconsistent with current federal law, copay maximizers are inconsistent with the EHB coverage requirements, and alternative funding programs cause avoidable delays and denials of necessary treatments to consumers. Aimed Alliance's work on these issues is available here: <https://aimedalliance.org/alternative-funding-programs/>.

carefully review formularies to ensure their medications were covered at open enrollment. As such, Amed Alliance urges Congress to require these programs to be clearly disclosed at open enrollment, along with a clear and transparent statement of the process for how a consumer will access their medication if required to work with a third party.

III. Improve Reporting Requirements on Consumer Protections

The annual rate review process is essential to ensure that increased premiums result in meaningful improvements in coverage and quality of care. However, like many insurance oversight practices, the burden often falls on the public to show that increased costs are unmanageable for consumers and caregivers. Therefore, Amed Alliance urges Congress to ensure that any revisions to rate review processes place an affirmative responsibility on plans to justify why increased costs to consumers are necessary and to reject default acceptances of rate increases.

Moreover, Amed Alliance also urges Congress to empower states with resources to better enforce existing consumer protection laws to ensure consumers receive the benefits they are entitled to. Based on Amed Alliance's 2025 comprehensive 50-state report, states lack consistent, active oversight efforts that proactively address non-compliance; as a result, upholding consumer protection laws depends on consumers filing complaints.⁵

Amed Alliance's 2025 report focused on how state insurance commissioners monitor reporting requirements related to utilization management, step therapy, and internal and external appeals. The findings reveal significant gaps in data collection, transparency, and proactive oversight. For example, only four states require health plans to report specific data on step therapy and prior authorization.⁶ This limited reporting makes it hard to understand how often these utilization management policies are used, whether they are used to deny care, and whether the plan saves money or improves patient outcomes as a result.

Outside of utilization management tracking, states generally have better processes in place to monitor claim denials, internal, and external appeals. However, these practices are not widespread, with less than half of all U.S. states requiring health plans to report data related to internal appeals, external appeals, or both;⁷ and only 17 of these states provide this data publicly

⁵ Amed Alliance, *2025 State Report: Step Therapy, Oversight, & Artificial Intelligence Trends and Best Practices* (Jun. 2025), https://aimedalliance.org/wp-content/uploads/2025/06/AA-2025StateReport_June_2025.pdf.

⁶ Kentucky, Maine, Massachusetts, and Maryland.

⁷ Arkansas, California, Connecticut, Delaware, Hawaii, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New York, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Utah, Washington, and Wisconsin. More than twenty states do not provide publicly available information regarding oversight activities or compliance monitoring: Alabama, Alaska, Colorado, Florida, Idaho, Illinois, Louisiana, Mississippi, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Vermont, Virginia, West Virginia, Wyoming.

through either an annual report⁸ or request.⁹ Moreover, only three states maintain consumer-facing reports or databases related to grievances or complaints filed with insurance departments.¹⁰

When appeals data was publicly available, Aired Alliance attempted to evaluate how often denials were overturned. However, inconsistent reporting standards, timeframes, and data elements across states made meaningful comparisons difficult. Despite these limitations, the available data consistently showed that when utilized, external appeals are approved at least one-third of the time. Data from Indiana and Pennsylvania further revealed that over 40 percent of internal appeals are reversed in favor of the consumer, suggesting that many claims denied in the first instance should never have been denied.

Despite the high reversal rate of first-level appeals, these protections are underutilized by consumers. Notably, Pennsylvania's 2023 data showed that out of 2,135,041 denied claims, only 3,156 internal appeals were filed, which is less than one percent of all denials. This disparity demonstrates the fundamental inadequacy of relying on appeals and consumer complaints as the primary mechanism for regulatory oversight.

Due to the burdensome nature of the appeals and complaint processes across state-regulated plans, it is critical that Congress develops reporting requirements for health plans regarding the number of claim denials, the reasons for denials, appeals, and appeal outcomes. Congress should also require health plans to report specific data related to the use of utilization management policies like step therapy and prior authorization. Specifically, Congress should require health plans to report the items and services subject to step therapy or prior authorizations, exception requests, specialties impacted, and cost savings derived as a result of utilization management policies. Providing this type of data to regulators can help policymakers identify specific conditions and therapeutic categories that are targeted, and if these policies are effective cost-savers for the health care system.

If reported more widely, this information could be illuminating for policymakers. For example, Connecticut's 2024 Consumer Report Card found that "other utilization review protocols," like step-therapy, saved plans an estimated \$4 per member per month.¹¹ These savings do not account for the cost to health care providers, negative health consequences, or other financial implications of utilization management. Thus, understanding how these policies impact the larger health care system and costs is critical to reforming health insurance that works

⁸ Nine states publish annual reports with this data: California, Connecticut, Hawaii, Indiana, New York, Pennsylvania, Utah, Washington, and Wisconsin.

⁹ Eight states provided the data to Aired Alliance upon request: Delaware, Iowa, Kentucky, Minnesota, Missouri, Nebraska, Oklahoma, and Rhode Island.

¹⁰ Colorado, Michigan, and Wisconsin.

¹¹ Connecticut Insurance Commissioner, *Consumer Report Card on Health Insurance Carriers in Connecticut* (Oct. 2024), <https://portal.ct.gov/cid/-/media/cid/reports/consumer-report-card/2024-consumerreportcard.pdf?rev=94d0c6b1e170408b974006006dbe6751&hash=81474DB06393007646988C1A5C55116F>.

for everyone. These reporting requirements can also help identify a pattern of large claim denials resulting from artificial intelligence systems arbitrarily denying claims.

Lastly, beyond these reporting requirements, Aired Alliance urges Congress to develop meaningful penalties when health plans use appeals processes and utilization management policies to deny consumers the benefits they are entitled to. For example, before 2019, CMS operated a “formulary administration analysis” monitoring program that reviewed pharmacy rejections to determine whether the plan was acting consistently with its requirements. Under the program, if a health plan had a pharmacy claim failure rate of 20 percent or higher, the plan would receive a letter notifying it of non-compliance.¹² If a plan was found to be non-compliant, CMS could also send warning letters, impose civil monetary penalties, and impose sanctions on health plans.¹³ Aired Alliance urges Congress to develop similar benchmarks to create concrete opportunities to monitor how these processes affect access and affordability.

IV. Ensure the Appeals Process is Reasonable Without Third-Party Interference

Aired Alliance applauds the report’s recognition of the challenges with claim delays and denials and the importance of the right to appeal established in the Patient Protection and Affordable Care Act. Aired Alliance is particularly concerned about the growing use of third-party companies referred to as alternative funding programs (AFPs) that interfere with this right.

AFPs are primarily used by large-group and self-insured health plans. When a health plan adopts an AFP, certain covered prescription drugs are diverted into an alternative coverage process. Under this process, consumers must first obtain prior authorization establishing that the medication is medically necessary. If the drug is approved, the health plan then requires the consumer to work with a third-party company to access the medication. The third-party company typically requires the consumer to apply to pharmaceutical manufacturer patient assistance programs (PAPs), which are intended to provide free medications to uninsured or underinsured individuals. In some cases, when consumers are deemed ineligible for the PAP, AFPs also require the consumer to obtain the medication through an international pharmacy. If neither option is available, the prescription is sent back to the health plan and covered through the typical pharmacy benefit. Although AFPs may appear financially advantageous to plans because AFP vendors charge plans 20 to 30 percent of the savings generated when a drug is obtained through an alternative source, these programs can create significant challenges for consumers.¹⁴

For consumers, these programs are confusing and leave them unable to challenge coverage decisions, causing harmful delays in accessing necessary treatments. First, AFPs are often

¹² U.S. Dep’t of Health & Hum. Servs., Off. of Inspector Gen., *Some Medicare Part D Beneficiaries Face Avoidable Extra Steps That Can Delay or Prevent Access to Prescribed Drugs*, OEI-09-16-00411 (Sept. 2019), <https://oig.hhs.gov/documents/evaluation/3141/OEI-09-16-00411-Complete%20Report.pdf>.

¹³ *Id.*

¹⁴ Anastassia Gliadkovskaya, A new wave of middlemen offers ‘alternative funding’ for specialty drugs. Patients bear the risk (Oct. 14, 2025), <https://www.fiercehealthcare.com/payers/new-wave-middlemen-promise-savings-specialty-drugs-patients-bear-risks>.

difficult for consumers to understand and navigate. In many cases, a consumer receives a determination that the prescribed medication is medically necessary, only to be told that they must work with an AFP to access the drug. During this process, consumers do not receive a formal denial letter stating the drug is not covered. As a result, consumers have no opportunity to appeal the requirement to work with the AFP to access their medications. Instead, consumers may be required to disclose personal, financial, and health information to the AFP and, in some cases, at the direction of the AFP, provide inaccurate information to PAPs to qualify for these programs that were designed for uninsured or underinsured individuals.¹⁵ For consumers who do not qualify for a PAP, some AFPs require them to import their medications from pharmacies located outside the United States, even when the medication is readily available in the United States.¹⁶ It is only after the PAP and international pharmacy are pursued and unavailable that the health plan will provide a coverage decision and agree to cover the medication as a typical pharmacy benefit.

Second, AFPs also create substantial delays in access to treatments. A 2024 survey of consumers enrolled in AFPs found that, on average, consumers waited over two months to receive their covered prescription drugs.¹⁷ Similarly, a study by Vanderbilt Specialty Pharmacy found that consumers enrolled in an AFP were 47 percent more likely than non-AFP consumers to experience a treatment gap, and nine times more likely to experience a poor clinical outcome, such as disease progression or hospitalization, because of delays in treatment.¹⁸ These findings underscore the significant risks AFPs pose to patient health and continuity of care. Delaying access to necessary medications can worsen health outcomes, increase the likelihood of preventable complications, and ultimately lead to higher overall health care spending. Ultimately, AFPs do not serve the best interests of consumers and may increase long-term health care costs. As such, Aired Alliance urges Congress to take action to address the use of these programs and ensure consumers can access their right to their necessary treatments and right to appeal.

V. Address PBM Reform and Vertical Integration

Pharmacy Benefit Managers (PBMs) are powerful middlemen in the health care system that manage prescription drug benefits on behalf of insurers. While PBMs were originally created to streamline pharmacy benefits and help lower drug costs, their growing influence and lack of transparency have raised serious concerns about affordability, access, and fairness.

¹⁵ *Id.*

¹⁶ Importantly, in 2026, the Food and Drug Administration confirmed that this type of mandatory importation is not consistent with FDA's personal importation policy or Section 804 programs. Aired Alliance, FDA Confirms AFPs Not Permissible Under Section 804, <https://airedalliance.org/fda-confirms-afps-not-permissible-under-section-804/>.

¹⁷ William B. Wong, et al., A descriptive survey of patient experiences and access to specialty medicines with alternative funding programs, *J. Manag Care Spec Pharm.* (Nov. 2024), <https://pmc.ncbi.nlm.nih.gov/articles/PMC11522444/>.

¹⁸ Karen Blum, AFPs Affect Access to Specialty Medications, *Specialty Pharmacy Continuum* (Oct. 2025), <https://www.specialtypharmacycontinuum.com/Online-First/Article/10-25/AFP-Affect-Access-to-Specialty-Medications/78765>.

PBMs first became part of the prescription drug supply chain in the 1960s when private insurers began carving out prescription drug coverage as a separate benefit from general medical care. At the time, insurers started relying on PBMs to handle a variety of administrative tasks from issuing prescription drug ID cards and electronic record keeping to larger responsibilities like processing pharmacy claims and managing prescription drug formularies. While the role of PBMs was initially narrower, over the last few decades, prescription drug benefits have become more complex, resulting in PBMs taking on a much larger role. Amed Alliance urges Congress to address PBM practices by banning spread pricing, addressing rebate-driven formularies, and addressing vertical integration.

PBMs may charge health plans more for a prescription drug than reimburse the pharmacy that dispenses it. For example, a PBM reimburses a pharmacy \$100 for a prescription drug but then charges the health plan \$130 for the same drug, keeping the \$30 difference, or “spread,” as profit. This practice raises concerns about inflated drug costs, excessive PBM profits, and a misalignment of incentives that may not benefit patients or the healthcare system.¹⁹ Congress has already recognized the harm of spread pricing and banned this practice in Medicare Part D. It should do the same across all health plans to protect health care consumers.

Congress must also address the role rebates play in establishing formularies. Rebates heavily influence which medications are included in formularies and at what cost-sharing levels. When determining which prescription drugs to place on the formulary, PBMs consider clinical effectiveness and cost, but often prioritize prescription drugs that have the largest rebates given as PBMs often receive a percentage of the rebate. The current rebate system can also perpetuate increasing prescription drug costs as rebates are often tied to the drug list prices, thereby incentivizing PBMs to keep drug prices high to receive larger rebates. Congress should prohibit the use of rebates within health insurance.²⁰

Lastly, Congress must address the vertical integration of insurers, specialty pharmacies, and health care practices. As vertical integration within the health care industry continues to expand, consumers will experience increased out-of-pocket spending and higher premiums as lower cost alternatives for care become unavailable.²¹ Amed Alliance encourages Congress to pursue reforms that separate integrated entities, like health insurers merged with pharmacy benefit managers, and to ensure these entities can negotiate without conflicts of interest to lower health care costs for health care consumers.²²

¹⁹ Amed Alliance, *Pharmacy Benefit Managers: Their Role, Impact, and the Need for Reform*, <https://aimedalliance.org/wp-content/uploads/2025/09/AA-PBM-FactSheet-Sept2025.pdf>.

²⁰ *Id.*

²¹ Georgetown University Center on Health Insurance Reform, *Vertical Integration on Health Care: Implications for Consumers, Employers, and Clinicians* (May 12, 2026), <https://chir.georgetown.edu/vertical-integration-in-health-care-implications-for-consumers-employers-and-clinicians/>

²² *Id.*

VI. Conclusion

In conclusion, Aired Alliance appreciates the opportunity to provide feedback on how Congress can make health insurance affordable for all. We urge Congress to pursue reforms that address the core drivers of unaffordability, including PBM reform, consumer protection oversight, and consumer out-of-pocket costs. Please contact us at avantrees@airedalliance.org if you have any questions.

Sincerely,

Ashira Vantrees

Director of Legal Strategy & Advocacy