



August 14, 2026

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Submitted electronically to: drugs@finance.senate.gov

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

Dear Ranking Member Wyden:

On behalf of the Obesity Action Coalition (OAC), thank you for the opportunity to provide comments in response to the Senate Finance Committee minority staff's Request for Information (RFI) on Commonsense Policy Options to Lower Drug Prices for Patients. We appreciate your leadership in seeking durable solutions that lower prescription drug costs, improve affordability for patients and sustain meaningful biopharmaceutical innovation.

OAC is a national nonprofit organization dedicated to improving the lives of people affected by the disease of obesity through education, advocacy, awareness and support. For nearly two decades, OAC has worked to elevate understanding of obesity as a complex, chronic disease, eliminate weight bias and discrimination, and expand access to comprehensive, evidence-based obesity care.

OAC strongly supports the Committee's recognition that current coverage for glucagon-like peptide-1 (GLP-1) receptor agonists and other Food and Drug Administration (FDA) approved obesity medications remains inconsistent and inadequate across Medicare, Medicaid, employer-sponsored insurance and the individual market. The RFI appropriately acknowledges that even when a plan nominally covers these medications, patients may encounter restrictive prior authorization requirements, high out-of-pocket costs and frequent prescription denials.

For too long, people living with obesity have been excluded from access to evidence-based care or required to develop additional diseases before treatment becomes available. This is not clinically appropriate, equitable or sustainable. Obesity is a serious chronic disease, and



people affected by it should have access to the full range of FDA-approved treatment options based on medical evidence, clinical judgment and their individual health needs, preferences and goals.

OAC supports exploring a prescription drug subscription model as one potential tool among other value-based payment models to lower the cost of obesity medications and expand access. However, a lower price paid by a government program, health plan or employer will not, by itself, ensure meaningful access for patients. Any subscription or value-based payment model must connect favorable enforceable coverage, affordability and patient-protection standards.

Our recommendations are outlined below.

I. Establish Broad and Dependable Coverage Across Insurance Markets

OAC supports the Committee's interest in exploring subscription arrangements and other value-based payment models that can lower costs, expand access and align payment with meaningful patient benefit across Medicare, Medicaid, commercial insurance and employer-sponsored coverage. Separate operational approaches may be necessary because these markets have different statutory authorities, financing structures and contracting arrangements. Nevertheless, patients should receive comparable core protections regardless of where they obtain coverage.

Any payment model should establish minimum national standards addressing:

- Coverage of FDA-approved obesity medications;
- Evidence and guideline-based clinical criteria;
- Affordable and predictable cost-sharing;
- Minimal utilization-management requirements;
- Treatment continuity;
- Formulary exceptions and appeals;
- Access to multiple clinically appropriate treatment options; and
- Public reporting and program evaluation.

A fragmented system in which patients have access under one plan but not another would perpetuate many of the inequities models are intended to address. Patients should not lose access because they change jobs, move between states, transition from Medicaid to employer coverage, enroll in a different Medicare plan or otherwise experience a change in insurance.



II. Structure Participation Around Patient Benefit

The Committee appropriately asks whether participation in a subscription model should be voluntary or mandatory. OAC believes both approaches present important opportunities and tradeoffs, and that the central policy question should be broader than participation alone.

A mandatory model could promote more consistent access across plans and reduce geographic or market variation. At the same time, a voluntary model may allow greater flexibility, encourage experimentation and make it easier to test different approaches across diverse insurance markets. Either structure, however, could fall short if payment incentives are not designed around meaningful patient benefit.

OAC therefore encourages the Committee to consider a broader range of value-based payment models, including but not limited to subscription arrangements. These approaches could include outcomes-based contracts, population-based payments, shared-savings arrangements or other models that better align payment with improved access, affordability, continuity of care and patient health.

Importantly, payment should not be tied simply to increased utilization or the number of prescriptions filled. Incentives based primarily on volume could encourage treatment decisions that are disconnected from individual clinical need and patient preference. Instead, payment should be connected to whether patients are able to access appropriate treatment, afford their medication, remain on therapy when clinically appropriate and experience meaningful health and quality-of-life benefits.

Regardless of whether participation is voluntary, mandatory or structured through another value-based model, OAC recommends that participating plans be held to clear and transparent patient-centered standards. These should include reasonable coverage criteria, predictable cost-sharing, timely authorization and appeals, continuity-of-care protections and access to clinically appropriate treatment options.

The goal should be to create payment models that reward value to patients rather than volume of treatment, while preserving flexibility for plans, providers and manufacturers to develop approaches that can improve access and outcomes over time.

III. Cover Obesity Before Additional Diseases Develop

The subscription or other payment model should include FDA-approved medications indicated for the treatment of obesity. Eligibility should not be limited to patients who



already have diabetes, cardiovascular disease, obstructive sleep apnea or another obesity-related condition.

Coverage policies that require people to develop an additional disease before receiving treatment are inconsistent with the principles of prevention and early intervention. Such requirements create an inequitable hierarchy under which a medication may be covered for one condition but excluded when prescribed to treat obesity itself.

Patient eligibility should be based on the FDA-approved indication, relevant clinical evidence and individualized decision-making between the patient and a qualified healthcare professional.

Policymakers should avoid creating eligibility criteria that are more restrictive than the FDA-approved indication without a compelling clinical justification.

The model/s should also provide a timely and transparent process for incorporating:

- Newly approved obesity medications;
- New indications for existing medications;
- New formulations and dosage forms;
- Emerging safety and effectiveness evidence;
- Changes in clinical guidelines; and
- New market entrants (dozens of obesity drugs coming to market in the next 5 or 10 years) that may improve competition or patient choice.

IV. Protect Continuity of Treatment

Continuity of care must be a foundational requirement of any subscription model. Obesity is a chronic disease, and many patients may require long-term treatment. Coverage policies should reflect the clinical reality that successful treatment may need to continue to maintain health improvements.

Patients who are stable on a medication should not be forced to discontinue or switch treatment solely because a contract expires, a different manufacturer receives preferred status or the patient changes plans. Agreements with manufacturers should be long enough to provide predictable access, and the model should include transition protections when agreements are renegotiated.

OAC recommends that the model:

- Prohibit arbitrary duration limits;
- Prohibit coverage termination solely because treatment has been successful;
- Prevent patients from being required to repeatedly demonstrate that they still have obesity after treatment has improved their weight or health;



- Provide sufficient notice before formulary or coverage changes;
- Require transition fills and continuity protections during plan changes;
- Protect patients who are stable on treatment from nonmedical switching; and
- Require an individualized clinical exception when continued access to a current medication is medically appropriate.

A program that expands treatment initiation but permits widespread involuntary discontinuation would not provide meaningful access and could undermine patient health.

V. Translate Negotiated Savings Into Patient Affordability

A value-based arrangement should demonstrate that financial savings translate into improved affordability and access for patients, but payer savings are not themselves evidence of patient benefit. A successful value-based payment arrangement must reduce costs for patients, not only for plans and government programs. Patients should not continue to face high deductibles or percentage-based coinsurance calculated from a list price that bears little relationship to the amount ultimately paid under a subscription or other value-based payment model.

OAC supports the Committee's consideration of cost-sharing based on net rather than list prices. We also support extending monthly out-of-pocket caps to additional chronic-disease medications and explicitly including FDA-approved obesity medications within such protections.

Patient affordability standards should include:

- A low, fixed monthly copayment;
- Protection from percentage-based coinsurance tied to the list price;
- No application of a separate prescription drug deductible to covered obesity medications;
- Application of negotiated savings at the pharmacy counter;
- A clear annual out-of-pocket maximum; and
- Additional assistance for people with low incomes.

OAC also supports expanding eligibility for the Medicare Part D Low-Income Subsidy program and eliminating unnecessary administrative barriers that prevent eligible beneficiaries from receiving assistance.

The value of a payment model should be measured in part by what patients actually pay. A model that reduces payer expenditures while leaving treatment unaffordable at the pharmacy counter would fail to accomplish the Committee's patient-centered objectives.

VI. Limit Restrictive Utilization Management

The RFI correctly recognizes that coverage does not always translate into affordable access. Patients may face high costs, prior authorization, step therapy, repeated reauthorization,



restrictive body mass index thresholds, mandatory participation in specific lifestyle programs or other requirements that delay or prevent treatment.

OAC recognizes that reasonable utilization management may have a role in ensuring clinically appropriate prescribing. However, requirements should be evidence-based, transparent, consistently applied and no more restrictive than necessary.

The model should prohibit:

- Requirements that conflict with the FDA-approved indication;
- Mandatory failure on non-equivalent treatments before access is permitted;
- Arbitrary or excessively narrow BMI thresholds;
- Repeated documentation of a chronic diagnosis without clinical justification;
- Requirements to achieve or maintain a specific amount of weight loss when continued treatment remains clinically appropriate;
- Mandatory participation in a proprietary lifestyle program as a condition of medication coverage;
- Automatic discontinuation following temporary gaps in treatment;
- Denials based solely on a patient's previous treatment history; and
- Delays caused by duplicative or unnecessary administrative documentation.

Prior authorization decisions should be timely, and patients should have access to a clear, accessible and independent appeals process. Plans should be required to report approval, denial, abandonment and appeal outcomes so policymakers can determine whether administrative controls are undermining access.

VII. Preserve Individualized Treatment and Medication Choice

Obesity treatment is not one size fits all. Patients may respond differently to individual medications, and treatment decisions may be influenced by clinical response, side effects, contraindications, comorbidities, dosing needs, route of administration and patient preferences.

A subscription or other value-based payment model should therefore avoid a winner-take-all approach that limits all patients to a single preferred product. Payment incentives should not encourage initiation, continuation, discontinuation or switching of treatment based primarily on financial considerations. Clinical decisions should remain between patients and their healthcare professionals.

OAC recommends that a potential model:

- Include multiple treatment options whenever feasible;



- Require coverage exceptions when a preferred medication is contraindicated, ineffective or not tolerated;
- Establish a simple and timely process for switching therapies;
- Protect stable patients from nonmedical switching;
- Permit access to a nonpreferred option when supported by clinical judgment; and
- Preserve shared decision-making between patients and their healthcare professionals.

Manufacturer competition should be used to improve affordability without sacrificing access to clinically appropriate care.

VIII. Ensure Adequate Federal Support and Equity in Medicaid

A subscription or other value-based payment model could help states address concerns about the budget impact of expanding obesity medication coverage. However, adequate and dependable federal financing will be essential.

Federal support should be structured so that states are not forced to reduce other healthcare services to participate. A model should also establish minimum coverage and access standards that apply to both fee-for-service Medicaid and Medicaid managed-care organizations.

Participating state programs and managed-care plans should be prohibited from imposing treatment-duration limits or utilization-management requirements that are inconsistent with

federal standards. States should also report data on approvals, denials, appeals, treatment persistence and patient out-of-pocket costs.

A national approach should seek to reduce, rather than reinforce, the current state-by-state variation in access. A person's ability to receive evidence-based obesity treatment should not depend primarily on where they live.

IX. Support Employer Participation While Protecting Employees

Employers frequently cite cost and uncertainty about future utilization when deciding whether to cover obesity medications. A subscription, outcomes-based, population-based or other value-based model may make these costs more predictable and could create a pathway for broader employer participation, particularly among small and midsized employers.

However, employee protections must accompany employer participation. The model should address:

- Whether self-funded plans will be included;
- How costs will be distributed among employers and plans;
- How smaller employers will be protected from disproportionate costs;



- Whether employers or plans may opt out;
- How access will be maintained when an employee changes jobs;
- Whether coverage will extend to dependents; and
- Whether employers may impose separate wellness-program requirements as a condition of access.

Any member-weighted assessment should be designed transparently and should not encourage plans or employers to avoid enrolling people with obesity. The financing structure should also recognize the value of equitable access across a broad risk pool.

X. Pair Medication Access With Qualified Medical Oversight and Comprehensive Care

Expanding medication coverage may substantially increase the number of people seeking obesity treatment. The healthcare system must be prepared to provide appropriate prescribing, follow-up and monitoring.

Medication access should be supported by qualified medical oversight and access to comprehensive care based on the needs and preferences of the individual patient. This may include primary care, obesity medicine specialists, nutrition services, behavioral healthcare, metabolic and bariatric surgery, and other evidence-based interventions.

However, access to medication should not be conditioned on participation in services that are unavailable, unaffordable or not clinically necessary for the individual patient. Comprehensive care should expand patient options rather than become an additional barrier.

The model should also include patient education regarding:

- Expected benefits and potential side effects;
- Appropriate medication use and monitoring;
- Differences between FDA-approved medications and compounded or unregulated products;
- The importance of obtaining treatment through legitimate healthcare and pharmacy channels; and
- How to report adverse events or product-quality concerns.

Improved coverage may also reduce the pressure that currently drives some patients toward unregulated or illegally marketed peptide products. People living with obesity should not be forced to choose between unaffordable FDA-approved treatment and products of uncertain identity, quality, purity or potency.



XI. Address Medication Supply and Pharmacy Access

A subscription model is likely to increase utilization. Policymakers should therefore assess manufacturing capacity, distribution, pharmacy participation and the potential for supply disruptions before implementation.

Manufacturer agreements should include:

- Realistic production and supply commitments;
- Equitable distribution across regions and insurance markets;
- Contingency planning for supply interruptions;
- Advance notification of anticipated shortages;
- Protections against preferential allocation to more profitable markets; and
- Transparent reporting on product availability.

Patients should also have meaningful access through retail, specialty and mail-order pharmacy channels, as appropriate. Plans and pharmacy benefit managers should not be permitted to impose pharmacy-network restrictions that create unreasonable travel, shipping delays or treatment interruptions.

XII. Coordinate Value-Based Payment Models With Medicare Drug Price Negotiation

The Committee asks how a value-based payment model should interact with the Medicare Drug Price Negotiation Program. OAC recommends that the two approaches be coordinated to maximize affordability and avoid duplicative or conflicting payment arrangements.

A subscription or other value-based agreement should not be used to delay or avoid eligibility for Medicare negotiation. Conversely, Medicare-negotiated prices should inform the reasonableness of subscription or other payments and help ensure that taxpayers and patients receive meaningful value.

CMS should establish transparent rules addressing:

- How subscription payments and rebates affect calculation of net prices;
- How a maximum fair price applies to medications included in a value-based arrangement;
- Whether subscription or other model participation changes manufacturer negotiation obligations;
- How savings will be passed through to beneficiaries;
- How utilization and spending will be reported; and
- How the government will prevent duplicate payments.



The objective should be to use the combined purchasing power of Medicare and other participating markets to improve access while maintaining fiscal responsibility.

XIII. Build in Regular and Transparent Renegotiation

Agreements should be reviewed on a predictable schedule and when material changes occur. OAC recommends scheduled review at least every two to three years, with earlier reconsideration when warranted by:

- Entry of a new medication or manufacturer;
- Approval of a new indication;
- Significant new clinical or safety evidence;
- Changes in manufacturing capacity;
- Material changes in utilization;
- Major changes in net pricing;
- Introduction of a generic, biosimilar or other competing therapy; or
- Evidence that patient-access standards are not being met.

Renegotiation should not disrupt treatment for patients already receiving medication. Patient representatives should participate in the review process, particularly when policymakers are considering changes to eligibility, coverage, cost-sharing or formulary structure.

XIV. Evaluate the Model Using Patient-Centered Measures

The success of the model should not be evaluated solely through total spending, prescription volume or weight change. Evaluation should determine whether patients can obtain, afford and continue the treatment selected with their healthcare professionals.

Required measures should include:

- Time from prescription to treatment initiation;
- Prior authorization approval and denial rates;
- Reasons for denial;
- Appeal volume and outcomes;
- Prescription abandonment;
- Patient out-of-pocket costs;
- Treatment initiation, persistence and discontinuation;
- Involuntary discontinuation and nonmedical switching;
- Medication availability and supply disruptions;
- Access to qualified healthcare professionals;
- Patient-reported health, functioning and quality of life;
- Patient experience with coverage and administrative processes; and



- Experiences of weight bias or discrimination.

Data should be stratified, where appropriate and consistent with privacy protections, by race, ethnicity, sex, age, disability, income, geography, rurality, insurance type and other relevant characteristics. This will help identify whether the program is reducing or widening existing disparities.

Evaluation should also distinguish between discontinuation based on a shared clinical decision and discontinuation caused by cost, denial, supply problems or administrative barriers.

XV. Include People Living With Obesity in Program Governance

People living with obesity should have a meaningful role in designing, implementing and evaluating the subscription model. Patient engagement should begin before program terms are finalized and continue throughout implementation.

OAC recommends establishing a formal patient advisory structure with representation from people with diverse treatment experiences, insurance types, geographic regions and demographic backgrounds. Patients should have opportunities to inform:

- Eligibility and coverage standards;
- Cost-sharing protections;
- Prior authorization and appeals;
- Patient communications;
- Outcome measures;
- Program evaluation;
- Contract renegotiation; and
- Corrective actions when access problems are identified.

Patient engagement should be adequately supported and compensated. It should not be limited to a one-time listening session after major decisions have already been made.

XVI. Continue Supporting Meaningful Obesity Research and Innovation

OAC supports efforts to lower excessive drug prices while preserving incentives for meaningful innovation. Significant unmet needs remain in obesity treatment. Patients need additional options with different mechanisms of action, delivery methods, safety profiles and therapeutic effects.

Federal innovation policy should support:

- Basic and translational obesity research;
- Development of treatments that address diverse patient needs;
- Comparative effectiveness research;



- Long-term safety and effectiveness studies;
 - Research on treatment maintenance and discontinuation;
 - Studies that include populations historically underrepresented in clinical trials;
 - Patient-centered outcomes beyond weight alone; and
- Development and validation of clinical outcome assessments that reflect how patients feel and function.

Research incentives should prioritize clinically meaningful advances rather than minor product changes designed primarily to extend exclusivity. People living with obesity should also be involved in establishing research priorities and defining outcomes that matter to the patient community.

Conclusion

OAC supports the Committee's exploration of a subscription model and other value-based payment models intended to lower prescription drug prices and expand access to evidence-based obesity care. A well-designed model could help address the fragmented and inequitable coverage system that currently leaves many people without access to treatment.

However, success must be defined by whether people living with obesity can obtain affordable, appropriate and continuous care, not simply by whether a lower price is negotiated. Favorable pricing should be directly linked to broad coverage, predictable cost-sharing, reasonable utilization management, continuity of treatment, individualized medication choice, transparent accountability and meaningful patient engagement.

OAC recommends that the Committee explore a model based on the following principles:

1. Recognize obesity medications as treatments for a chronic disease.
2. Establish broad coverage across Medicare, Medicaid, employer-sponsored and individual-market plans.
3. Require meaningful plan participation and enforceable access standards.
4. Pass negotiated savings directly to patients through low and predictable cost-sharing.
5. Prohibit utilization-management requirements that are unnecessarily restrictive or inconsistent with clinical evidence.
6. Protect continuity of treatment and prevent nonmedical switching.
7. Preserve access to multiple clinically appropriate treatment options.
8. Pair medication access with qualified medical oversight and comprehensive care options.
9. Require transparent, patient-centered evaluation and public reporting.
10. Include people living with obesity in the design, governance and evaluation of the model.

Thank you for your leadership and for considering the perspectives of people living with obesity as the Committee develops future legislation. OAC would welcome the opportunity to serve as a



resource and work with you and Committee staff to advance policies that improve the affordability, accessibility and quality of obesity care. Please contact Dr. Tracy Zvenyach, PhD with any questions at tzvenyach@obesityaction.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Joe Nadglowski", is positioned above the printed name.

Joe Nadglowski
President and Chief Executive Officer
Obesity Action Coalition