

August 17, 2026

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
Attn: Senate Finance Committee Democratic Staff
219 Dirksen Senate Office Building
Washington, DC 20510

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

Dear Ranking Member Wyden and Members of the Senate Finance Committee Democratic Staff:

On behalf of the National Alliance for Caregiving (NAC), thank you for the opportunity to respond to the Committee's June 16, 2026, Request for Information (RFI) on commonsense policy options to lower drug prices for patients.

Since 1996, NAC has been the leading voice raising awareness of America's family caregivers. Today, more than 63 million Americans provide unpaid care to a family member or friend, contributing an estimated \$1.01 trillion annually in unpaid labor – a figure that now exceeds combined federal, state, and local Medicaid spending nationwide and nearly doubles total out-of-pocket health care spending in the United States.¹ More than half of these caregivers, 57 percent, provide high-intensity care that includes complex medical and nursing tasks such as medication administration, wound care, and injections.² Family caregivers are an unpaid extension of the health care workforce. In that role, they are also the ones who fill prescriptions, track formularies, absorb copays, and navigate denials on behalf of the people to whom they provide care.

Nearly one in four family caregivers goes into debt because of caregiving responsibilities, and one in ten people carrying medical debt accumulated that debt while caring for someone else.³ Separately, AARP research finds that family caregivers spend an average of \$7,242 out of pocket annually on caregiving-related expenses – roughly a quarter of their income – with

¹AARP, "Economic Value of Family Caregiving Reaches \$1 Trillion Dollars Annually," press release, March 26, 2026, <https://www.aarp.org/press/releases/2026-03-26-AARP-Economic-Value-Of-Family-Caregiving-Report.html>.

²Ibid

³National Alliance for Caregiving, Cancer Caregiving Collaborative, "Financial Toxicity and Cancer Caregiving", citing National Alliance for Caregiving & AARP, Caregiving in the U.S. 2020, and Lopes, L., Kearney, A., Montero, A., & Brodie, M., "Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills," KFF, 2022, <https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/>.

medical costs, including prescription drugs, medical equipment, and provider visits, accounting for a meaningful share of that burden.⁴

NAC commends the Committee for pursuing policies that would directly reduce patients' out-of-pocket drug costs and address perverse incentives in the supply chain. Our comments below focus on the provisions in Section II of the RFI ("Enhancing Prescription Drug Affordability") most relevant to family caregivers' lived experience: capping out-of-pocket costs on more chronic care drugs, ensuring cost-sharing reflects net rather than list prices, holding PBMs accountable for steering patients toward higher-cost products, and stopping inappropriate pharmacy rejections. We also offer comments on expanding Low-Income Subsidy eligibility and reforming pharmacy dispensing fees.

I. NAC Priorities

A. Extend Out-of-Pocket Caps to More Chronic Care Drugs – and to Traditional Medicare

Family caregivers disproportionately manage medication regimens for people living with multiple, often complex chronic conditions – cancer, diabetes, cardiovascular disease, and COPD among them. The evidence the Committee cites confirms that the \$35 monthly insulin cap enacted in 2022 substantially reduced cost-sharing, increased medication adherence, and improved health outcomes for seniors. NAC urges the Committee to extend similar caps to additional classes of chronic care medications, including cardiovascular, respiratory (e.g., asthma and COPD inhalers), oncology, and other high-rebate chronic disease drug categories.

We further urge the Committee to structure any new caps as an overall monthly limit on total chronic care drug spending per beneficiary, rather than a series of separate per-drug caps. Caregivers frequently manage regimens involving multiple concurrent medications for a single care recipient with comorbid conditions. In turn, a cap that limits cost-sharing only drug-by-drug does little to address the cumulative burden of a multi-drug regimen, which is what truly drives caregiving families into debt.

NAC likewise supports extending an out-of-pocket cap to Traditional Medicare Parts A and B. Family caregivers of people undergoing physician-administered treatment face some of the steepest and least predictable costs in the system. No family should be one infusion away from bankruptcy, and a comprehensive out-of-pocket cap spanning both Part D and Parts A/B is necessary to prevent that outcome.

⁴AARP Public Policy Institute, "Family Caregivers Experience High Out-of-Pocket Costs," 2021 Caregiving Out-of-Pocket Costs Study, <https://www.aarp.org/caregiving/financial-legal/high-out-of-pocket-costs/> (average annual spending of \$7,242, or roughly 25 percent of income; medical expenses average over \$1,200 annually).

B. Hold Plans and PBMs Accountable for Inappropriate Pharmacy Rejections

Prior authorization denials and pharmacy rejections impose a disproportionate burden on family caregivers, who are frequently the ones responsible for identifying a denial, gathering documentation, and pursuing an appeal on behalf of a care recipient on top of their existing caregiving responsibilities. The RFI cites HHS Office of Inspector General findings that 73 percent of appealed Part D denials are ultimately overturned and a 2025 IQVIA study finding that beneficiaries who successfully overcame an initial denial experienced treatment delays of 14 to 24 days on average, with 10 to 19 percent facing delays of five weeks or longer. For a caregiver managing a family member's cancer treatment or a time-sensitive chronic condition, a five-week delay is not an administrative inconvenience – it is a direct threat to the health of the person they are caring for, layered onto the financial toxicity NAC's own research has documented.⁵

NAC supports CMS developing a Part D Star Rating metric tied to inappropriate rejection rates, making rejection rates more transparent through Medicare Plan Finder, and streamlining Part D appeals processes. We further urge the Committee to ensure any streamlined appeals process explicitly accommodates caregivers and other authorized representatives acting on a beneficiary's behalf. In NAC's own [comments last year to CMS](#) on Medicare data access, we highlighted that caregivers are too often required to re-establish their authority to act at every step of a fragmented process, which itself contributes to delay. Building caregiver-designated access into the Part D appeals process – not only clinical data systems – would meaningfully reduce the time-to-treatment gap the RFI identifies.

C. Expand Low-Income Subsidy (LIS) Eligibility to 200% FPL and Eliminate the Asset Test

NAC supports raising LIS income eligibility to 200 percent of the Federal Poverty Line and eliminating the asset limit. Beneficiaries and caregiving households whose income sits just above the current LIS threshold face a steep affordability “coverage cliff” and often are experiencing real financial strain despite technically appearing ineligible for assistance. Family caregivers frequently supplement the income of the low-income parents, spouses, and family members they care for, and many caregivers are themselves older adults living on fixed or limited incomes. The current asset test penalizes exactly the kind of modest emergency savings that NAC encourages caregiving families to build. Eliminating it would reduce a source of financial precarity for both beneficiaries and the caregivers who support them. This proposal is consistent with NAC's broader advocacy for the economic inclusion and financial well-being of family caregivers, in line with the National Strategy to Support Family Caregivers.⁶

⁵National Alliance for Caregiving, Cancer Caregiving Collaborative, "Financial Toxicity and Cancer Caregiving".

⁶Ibid

Raising the threshold is necessary, but not sufficient. NAC urges the Committee to take the following additional steps:

- Strengthen outreach and enrollment support for beneficiaries who are eligible for LIS but not yet enrolled.
- Ensure current LIS enrollees who are still paying a Part D premium are informed that \$0-premium plan options are available to them.
- Examine whether enrollment procedures and periodic eligibility redetermination requirements – not just the asset test – create avoidable administrative barriers for caregivers helping a family member establish and maintain LIS coverage.

D. Bolstering Biopharmaceutical Innovation

NAC supports the Committee's efforts to bolster biopharmaceutical innovation, as upstream investments in R&C, clinical trials and scientific talent directly correlate to the family caregiver experience. Earlier diagnosis gives families more time to plan and prepare for care and reduces the financial burden of diagnostic delay. Breakthroughs that emerge earlier are studied more efficiently, and are designed with real-world use in mind can reduce the downstream burden caregivers absorb – fewer hospitalizations to coordinate, fewer complex regimens to manage without support, and fewer years spent cycling through trial-and-error treatments before an effective therapy is found. Policies that accelerate the development of effective therapies ultimately produce better outcomes for patients and meaningful cost and time savings for the caregivers supporting them.

NAC urges the Committee to consider caregivers specifically as it develops policy in the following areas:

- Facilitate caregiver involvement in research and innovation, including clinical trials, real-world data collection, and patient-centered therapy design. Caregivers offer unique, practical insight into how therapies perform outside the clinical setting.
- Account for caregiver burden in clinical trial design, including support such as travel reimbursement, flexible scheduling, and remote monitoring options that make participation feasible for patients who rely on a caregiver.
- Ensure that resulting therapies are developed with caregiver administration in mind, so that treatment innovation translates into treatments that are usable and sustainable in the home setting.

Beyond these specific policy areas, NAC also encourages the Committee to consider a structural precedent set by the CHIPS and Science Act. When implementing the law, the Department of Commerce required applicants seeking more than \$150 million in direct funding to submit plans for providing affordable, high-quality child care to facility and construction

workers – treating care infrastructure as part of industrial competitiveness. The Committee should carry this principle into any biopharmaceutical package and define it more broadly:

- **Caregiving obligations push people out of the scientific workforce** – particularly women researchers at the career stages when foundational discoveries are made – and also make it harder to enroll patients in clinical trials and to staff biomanufacturing facilities.
- **Tie funding and tax incentives to care policies.** Congress should encourage recipients of biopharmaceutical grants, loan guarantees, and tax incentives to adopt care policies, and tie utilization of any new tax credits to benefits such as paid family and medical leave, child care, elder care, and dependent-care support.
- **Build on existing models.** This could take the form of higher credit rates for firms that provide these benefits, or of expanding the existing employer credit for paid family and medical leave under Section 45S.

CHIPS recognized that semiconductor fabs cannot be staffed without supporting the workers who run them. The same principle applies here: an industry built on human talent will only succeed if its incentives account for the conditions that let scientists, technicians, and trial participants do the work.

Conclusion

Family caregivers are not a peripheral stakeholder in prescription drug policy – they are the ones administering the medications, absorbing the cost-sharing, and appealing the denials that this RFI addresses directly. NAC appreciates the Committee's attention to affordability and looks forward to continuing to work with the Committee as this policy develops. If you have questions, please contact Blaire Bryant at blaire@caregiving.org.

Respectfully submitted,

Jason Resendez
President and CEO
National Alliance for Caregiving