Chronic Care Policy Alliance | State Advocates Working Together to Bridge the Gaps in Chronic Care

January 21, 2026

The Honorable Jason Smith, Chair
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal, Ranking Member
House Committee on Ways and Means
1129 Longworth House Office Building
Washington D.C. 20515

Dear Chairman Smith, Ranking Member Neal and Members of the Committee:

On behalf of the Chronic Care Policy Alliance (CCPA), we appreciate the opportunity to submit remarks ahead of the committee's upcoming hearing examining insurance policies and their impact on patients.

CCPA is a national network of state and regional advocacy organizations united by a shared mission to improve the lives of those living with chronic conditions. Through policy advancements, coalition building, and advocacy efforts, CCPA amplifies the voices of those managing complex healthcare needs and works to ensure consistent access to affordable treatments and high-quality care.

We share the committee's interest in improving affordability and access to care. Insurance practices play a central role in shaping patient access and continuity of care for individuals living with chronic and serious health conditions. With the executives responsible for these policies appearing before the committee, this hearing presents an important opportunity for oversight and accountability. We urge the committee to raise the following issues to ensure that the impact on patients is fully understood and examined. As a next step, we also urge the committee to press for greater transparency and implement reforms that would reduce patient burden and better support health outcomes.

Patient Out-of-Pocket Costs and Affordability

For patients and families managing ongoing care, affordability is not an abstract concept. It reflects whether individuals can consistently access medically necessary treatments, testing, preventive services, and vaccinations without being forced to make untenable tradeoffs between health care and basic needs such as housing, food, or transportation. While insurance coverage can mitigate some costs, rising premiums, deductibles, and cost-sharing requirements continue to place growing financial strain on patients, particularly those who rely on multiple therapies over long periods of time.

Patients with chronic conditions are especially vulnerable to high and unpredictable out-of-pocket costs. Even with insurance, many face significant cost sharing through

deductibles, coinsurance, and copayments that accumulate quickly across multiple prescriptions and services. When affordability thresholds are exceeded, patients may delay care, skip doses, or forgo treatment altogether, which can worsen health outcomes and ultimately increase system-wide costs.

Copay Accumulator Policies

Copay assistance programs and financial aid can help many patients manage increasing out-of-pocket costs. These programs provide real financial support for patients with demonstrated need. However, insurer practices can significantly undermine their effectiveness.

Copay accumulators allow health plans and Pharmacy Benefit Managers (PBMs) to accept copay assistance payments without applying them toward a patient's deductible or out-of-pocket maximum. As a result, patients who rely on assistance are prevented from making meaningful progress toward their cost-sharing obligations, even though payments are being made on their behalf.

All patient payments, regardless of source, should count toward required cost-sharing limits. We urge Congress to advance policies that prohibit copay accumulator practices and restore basic affordability protections.

Utilization Management, Prior Authorization, and Step Therapy

Utilization management tools, including prior authorization and step therapy, are frequently justified as cost-containment mechanisms. In practice, these processes often override clinical judgment and interfere with timely patient care.

Prior authorization provisions require clinicians to seek insurer permission to access a treatment or test. This additional layer of review can delay care for days or months, impose substantial administrative burden on providers, and create uncertainty for patients. For individuals with chronic or progressive conditions, such delays can worsen outcomes and increase the likelihood of emergency care or more intensive interventions.

Step therapy policies compound these challenges by requiring patients to "fail first" on insurer-preferred treatments before accessing the therapy prescribed by their clinician. This approach can expose patients to ineffective treatments or adverse effects, prolong disease activity, and undermine adherence. Federal action is necessary to ensure consistent, patient-centered protections across coverage types.

Non-medical switching further disrupts care by forcing stable patients to change treatments for non-clinical reasons, often due to formulary changes or rebate arrangements. These disruptions can lead to loss of disease control, new side effects, and additional provider visits, all without improving patient outcomes.

Vaccines and Preventive Care Coverage

Vaccines have played an instrumental role in improving public health, preventing disease, and reducing long-term health care costs. Their impact on population health and individual well-being cannot be overstated. It is critical that insurance coverage supports broad and reliable access to recommended vaccines and preventive services. Maintaining consistent coverage without cost barriers is essential to protecting public health, particularly for medically vulnerable populations.

Telehealth Access and Coverage

Telehealth has become an essential tool for improving access to care, especially for individuals in rural areas, those with mobility limitations, and patients facing provider shortages. For many patients with chronic conditions, telehealth enables continuity of care that would otherwise be disrupted by travel burdens, transportation barriers, or limited specialist availability.

While temporary telehealth flexibilities expanded access in recent years, significant coverage and reimbursement barriers remain. Congress should prioritize making telehealth flexibilities permanent and ensure that insurance policies do not erect new financial or administrative obstacles that limit patient use of these services.

Consolidation and the Role of PBMs

Insurance market consolidation, including vertical integration involving PBMs, has concentrated decision-making power over formularies, utilization management, pharmacy networks, and reimbursement structures. PBMs now exert significant influence over which medications are covered, under what conditions, and at what cost to patients, often with limited transparency or oversight.

CCPA is concerned that PBM practices may prioritize financial arrangements over patient access and clinical appropriateness. Policymakers should examine how consolidation and PBM incentives affect affordability, access, and outcomes, and pursue reforms that increase transparency, accountability, and alignment with patient interests.

Conclusion

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This hearing presents a meaningful opportunity for congressional oversight and accountability. With the executives responsible for insurance coverage and benefit design decisions before the committee, we urge you to press for clear explanations, greater transparency, and concrete commitments to reform practices that place unnecessary burdens on patients. We appreciate your commitment to advancing policies that meaningfully improve affordability, access, and health outcomes for individuals living with chronic and serious health conditions.

Sincerely,

Elizabeth Helms
President
Chronic Care Policy Alliance