

October 2, 2026

The Honorable Ron Wyden
Senate Finance Committee
219 Dirksen Senate Office Building
Washington DC 20510

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

Dear Senator Wyden and members of the Senate Finance Committee:

The Rheumatology Nurses Society (RNS) appreciates the opportunity to share feedback on policies that can improve health coverage for patients across the United States. For many patients with rheumatologic diseases, prescription medications are an essential component of controlling disease activity, preventing disability, and maintaining quality of life. These patients may require specialty medications that are costly and complex to administer. As a result, they can be particularly vulnerable to formulary restrictions, changes in coverage, utilization management requirements, specialty pharmacy mandates, and other decisions made within the pharmacy benefit system.

The RNS is a not-for-profit professional organization committed to the development and education of nurses and other advanced practice providers (APPs) to benefit patients, family and community. We are dedicated to healthcare professionals who are passionate about and committed to rheumatology and the promotion of excellence in the delivery of patient care. We work to remain the gold standard of rheumatology nursing practice through the creation of rheumatology nursing standards and protocols, and by acting as a primary resource to healthcare professionals and the patients they serve.

Ensuring That Patients Do Not Face Hurdles or Delays in Accessing the Care They Need

Prior Authorization

Rheumatology nurses work alongside patients and their healthcare providers to coordinate treatment, manage complex medication regimens, and address barriers to care. We see firsthand how unnecessary administrative requirements can interfere with timely treatment and place significant burdens on both patients and clinical practices. Prior authorizations are a prime example of administrative burdens that do not ensure better healthcare outcomes. While prior authorizations can serve a legitimate purpose, the current system often operates differently from one health plan to another, with varying requirements, documentation standards, submission processes, and approval criteria. This lack of consistency can create substantial administrative work while delaying access to treatments that a patient's healthcare team has determined are medically appropriate.

For individuals living with rheumatoid arthritis and other rheumatologic diseases, delays can be particularly consequential. Treatment decisions frequently reflect years of experience with a patient's disease, previous therapies, comorbidities, medication tolerability, and response to treatment. Rheumatology nurses are

often directly involved in helping patients navigate these treatment plans and ensuring that therapies are administered and monitored appropriately. When an insurer requires additional steps before a prescribed treatment can begin, the resulting delay can disrupt carefully developed treatment plans.

A study published in [Arthritis Care & Research](#) found that 71% of patients receiving infused medications required prior authorization, while 96% of prior authorization requests were ultimately approved. These findings raise important questions about whether some prior authorization requirements are meaningfully evaluating medical necessity or instead creating delays before patients ultimately receive the treatment their clinicians prescribed. These delays in approval also impact continuity of treatment. Patients with chronic rheumatologic diseases may spend considerable time working with their healthcare team to identify a therapy that effectively controls their disease. Once an effective treatment has been established, repeatedly requiring the patient to demonstrate eligibility for that same therapy can create unnecessary disruption.

Furthermore, the RNS believes that patients who transition between health plans offered by the same insurance carrier should not be required to restart the prior authorization process for an ongoing, previously approved therapy when there has been no meaningful change in their clinical circumstances. Changes in employment, family circumstances, or benefit selections can require patients to select a different plan without changing their insurer or their underlying medical needs. Administrative changes within an insurance company's plan offerings should not unnecessarily interrupt an established course of treatment.

RNS believes that healthcare decisions should be made through a partnership between patients and the clinicians who understand their individual medical circumstances. Prior authorization should support appropriate, evidence-based care—not become an obstacle that delays treatment, disrupts continuity, or adds unnecessary administrative work to already strained clinical practices.

Step Therapy

While not expressly outlined in the RFI, step therapy is another utilization management tool that has been abused by health plans and pharmacy benefit managers (PBMs) at the detriment of patient care. The RNS encourages Congress to establish important protections for patients and providers navigating step therapy and other utilization management requirements, such as the *Safe Step Act* (S.2903/H.R.5509). As nurses who work closely with individuals living with rheumatoid arthritis and other rheumatologic conditions, we see firsthand how insurance restrictions can affect patients' ability to receive timely, appropriate, and continuous care.

Step therapy, sometimes referred to as “fail first,” requires a patient to use one or more medications selected by an insurer or PBM before the health plan will cover the medication prescribed by the treating clinician. While utilization management can have a role in the healthcare system, decisions about an individual patient's treatment should ultimately be guided by the patient's medical circumstances and the clinical judgment of the patient's healthcare team—not solely by an insurance formulary.

Rheumatologic diseases are often complex, chronic conditions that require individualized treatment plans. Finding an effective therapy can involve careful consideration of a patient's disease characteristics, treatment history, other medical conditions, potential drug interactions, and prior experiences with medications. Once an effective treatment has been identified, maintaining continuity can be essential to keeping disease activity under control. An insurance-mandated change in therapy can disrupt that stability and create additional challenges for both patients and their healthcare providers.

Our members regularly encounter situations in which a patient's established treatment is affected by formulary requirements or changes to a health plan's coverage policies. In some cases, patients can be required to move through additional treatment steps even after their clinician has determined that another therapy is medically appropriate. Changes to formularies or utilization management requirements during the course of treatment can make these circumstances particularly difficult to navigate.

The consequences extend beyond administrative inconvenience. When a clinically appropriate medication is delayed while a patient completes insurer-mandated steps, there is a risk that the patient's disease may flare up. For someone living with rheumatoid arthritis or another progressive rheumatologic condition, interruption or delay in effective treatment can mean increased symptoms, impaired ability to work or perform daily activities, and additional medical visits to address complications.

A step therapy exception process, as outlined in the *Safe Step Act*, would provide a mechanism for patients and healthcare professionals to seek an exception when there is a documented clinical reason that the insurer-preferred treatment is not appropriate for the patient. This approach recognizes the role of utilization management while also recognizing that standardized coverage policies cannot account for every patient's medical need. Patients and their providers should have access to a clear, timely, predictable, and clinically meaningful pathway for obtaining an exception when the circumstances of the individual patient warrant an alternative treatment. Such a process should not create unnecessary administrative barriers that effectively prevent clinicians from using their professional judgment.

Effective disease control can also have implications for overall healthcare utilization. For patients with rheumatoid arthritis, maintaining low disease activity or remission can help avoid the complications and additional healthcare needs associated with uncontrolled disease. Ensuring that patients can access medically appropriate treatment in a timely manner is therefore not simply a matter of convenience—it is an important component of comprehensive chronic disease management.

Vertical Integration of Big Insurers and Middlemen

The RNS recognizes that PBMs can perform legitimate functions within the prescription drug marketplace, including negotiating prices and administering pharmacy benefits. However, we are concerned that PBMs operate in a manner that continues to fail to improve affordability, transparency, and access. Instead, PBMs consistently demonstrate that they value profits over patient care.

Much of the PBM abuses stem are exacerbated because the current PBM marketplace is highly concentrated and vertically integrated. The Federal Trade Commission has reported that the three largest PBMs—CVS Caremark, Express Scripts, and OptumRx—processed nearly 80% of prescriptions dispensed in the United States in 2023. The FTC has also highlighted how the largest PBMs' integration with insurers and pharmacies can give them significant influence over how patients access their drugs and the cost of those medications.

The RNS is particularly concerned about the incentives within the PBM system that may influence formulary and pricing decisions. When PBM compensation is tied to a drug's list price or other financial arrangements, policymakers should ensure that these arrangements do not create incentives that conflict with the goal of obtaining affordable and appropriate treatment for patients. We recognize that some progress was made on this front through the *Consolidated Appropriations Act of 2026*, but we urge Congress to take additional steps to rein in the abusive practices of PBMs that fail to make health coverage work for everyone.

Recent federal action underscores the importance of greater transparency. The FTC has alleged that PBM-affiliated entities used rebating practices that contributed to artificially high insulin list prices and limited access to lower-list-price products. In February 2026, the FTC announced a settlement with Express Scripts that includes provisions addressing formulary practices, patient cost-sharing based on net prices, and fees linked to drug list prices. These findings demonstrate the need for Congress to ensure greater transparency by the PBMs, such as increased transparency in PBM compensation and pricing arrangements. PBMs should be required to provide meaningful information about the amounts they receive and retain throughout the prescription drug transaction, including the difference between payments made to pharmacies and amounts charged to health plans. Greater transparency would allow plan sponsors and policymakers to better evaluate whether negotiated discounts are actually translating into savings for patients.

We also support reforms that would remove incentives for PBMs to favor medications based on their list prices rather than their overall value and net cost. Compensation for PBM services should be structured in a way that does not reward the selection of higher-priced medications simply because those products generate larger percentage-based fees or rebates. In addition, the RNS supports policies that would ensure that rebates and other negotiated discounts provide a meaningful benefit to patients at the point of sale. Rheumatology patients who rely on expensive specialty medications can face substantial cost-sharing obligations. When a patient's coinsurance is calculated using a medication's list price rather than a lower net price after rebates and discounts, the patient may not experience the benefit of savings negotiated elsewhere in the drug supply chain.

We appreciate the Committee's interest in identifying policies that will help make health coverage work for everyone. We appreciate your consideration and look forward to working with Congress as it considers opportunities to address the cost of prescription drugs and patient access to life saving treatments.

Sincerely,

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