



Asthma and Allergy  
Foundation of America

August 17, 2026

Honorable Ron Wyden

United States Senate

Washington, D.C.

20510-3703

Submitted to [drugs@finance.senate.gov](mailto:drugs@finance.senate.gov)

Re: [Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients](#)

Dear Senator Wyden:

The Asthma and Allergy Foundation of America (AAFA) appreciates the opportunity to respond to the June 16 Request for Information on prescription drug pricing. As the nation's oldest and largest nonprofit patient organization dedicated to asthma, allergies, and related conditions, AAFA's mission is to save lives and reduce the burden of disease for people with asthma and allergies through support, advocacy, education and research.

Access to effective, affordable drugs is crucial for managing disease, yet the cost burden prevents many members of our community from accessing evidence-based care. Innovation is crucial, but meaningless if patients can't access the drugs they need.

We are aware that high drug prices are part of a complex set of factors impacting access. Insurer-level barriers to specific drugs, including adverse tiering and corresponding high costs, can lead to worse disease management and more asthma attacks. Similarly, utilization management approaches such as step therapy or prior authorization can delay access to appropriate care and lead to more attacks and higher healthcare costs. AAFA strongly supports policies that address all of these barriers to evidence-based care.



Our comments summarize our positions on a range of federal policies related to drug pricing. We also offer the patient perspective on drug pricing and access, gleaned from people living with asthma and allergies patients across our patient community.

### **Background: Asthma and Allergy in the U.S.**

Asthma is a chronic lung disease that causes airway inflammation and hinders breathing. Asthma is one of the most prevalent diseases in the United States, affecting nearly 28 million Americans and killing 9–11 individuals every day.<sup>1</sup> Asthma is also very expensive, with its economic toll in the U.S. expected to reach at least \$118 billion in 2026.<sup>2</sup>

The burden of asthma does not fall equally across populations. Compared to white Americans, Black Americans are 1.5 times more likely to have asthma, five times more likely to visit the emergency room due to asthma, and three times more likely to die from asthma.<sup>3</sup> Puerto Rican Americans are twice as likely as white Americans to have asthma.<sup>4</sup> These disparities are largely driven by social and structural factors, including economic factors and discrimination.<sup>5</sup>

Food allergies represent another significant health burden in the U.S., impacting 5.3% of children<sup>6</sup> and 6.7% of adults.<sup>7</sup> Black adults are more likely to have a diagnosed food

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<sup>1</sup> AAFA, Asthma Facts, Figures, and Stats. Available at <https://aafa.org/asthma/asthma-facts/>

<sup>2</sup> *Id.*

<sup>3</sup> AAFA, *Asthma Disparities in America* (2020). Available at <https://aafa.org/asthma-allergy-research/our-research/asthma-disparities-burden-on-minorities/>

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> Giri, Abhigya;Ng, Amanda E.;Bottoms-McClain, Lauren. Diagnosed Allergic Conditions in Children Ages 0–17: United States, 2024 (2026). National Center for Health Statistics (U.S.). Available at <https://stacks.cdc.gov/view/cdc/174635>

<sup>7</sup> Ng, Amanda E.;Giri, Abhigya;Bottoms-McClain, Lauren. Diagnosed Allergic Conditions in Adults: United States, 2024 (2026) National Center for Health Statistics (U.S.). Available at <https://stacks.cdc.gov/view/cdc/174634>.



allergy than white, Asian or Hispanic adults (9.9%, compared to 6.4%, 5.5%, and 5.4%).<sup>8</sup> Food allergies may result in a severe reaction called anaphylaxis that in rare cases can lead to death. Unfortunately, the prevalence and impact of food allergies in the U.S. are increasing; for example, the rate of emergency room visits for food-related anaphylaxis increased by 124% from 2005 through 2014.<sup>9</sup> Children with food allergies are also two to four times more likely to have asthma or other allergic diseases.<sup>10</sup>

### **Our Patient Community's Experience of Drug Pricing**

Proper care and disease management, including medication, can allow people with asthma and allergies to live healthy lives. Unfortunately, as detailed in our “My Life with Asthma” report, AAFA’s national survey of adults with asthma found that less than a quarter of respondents always used their asthma treatments as prescribed.<sup>11</sup> The top three reasons for not using treatments were related to cost: inability to afford treatment, treatment was too expensive, and lack of insurance coverage for the treatment.<sup>12</sup> High out-of-pocket costs hinder adherence, threaten the health of patients, and exacerbate disparities in health status.

AAFA hears regularly from patients and caregivers struggling to afford their medications. Patients report paying \$300–\$500 or more per month for controller inhalers and copays of \$800 to more than \$2,000 for biologic therapies. Some have lost access to manufacturer copay assistance when they aged into Medicare; others have had to apply to multiple charitable foundations or collect multiple denial letters required by some manufacturer programs, only to remain unable to afford their

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<sup>8</sup> *Id.*

<sup>9</sup> Motosue et al., “Increasing Emergency Department Visits for Anaphylaxis, 2005–2014.” *J Allergy Clin Immunol Pract.* 2017 Jan – Feb;5(1):171–175.

<sup>10</sup> Branum, A., & Lukacs, S. (2019). Food Allergy Among U.S. Children: Trends in Prevalence and Hospitalizations. Centers for Disease Control and Prevention; National Center for Health Statistics. <https://www.cdc.gov/nchs/products/databriefs/db10.htm>

<sup>11</sup> Asthma and Allergy Foundation of America, “My Life With Asthma: Survey Overview (2017). Available at <https://aafa.org/asthma-allergy-research/our-research/my-life-with-asthma-report/>

<sup>12</sup> *Id.*



medications. Still others share the inability to afford even a single quick-relief (“rescue”) inhaler.

## **AAFA’s Positions on Drug Pricing and Access**

### **I. Lowering Drug Prices**

#### *Expanding and Monitoring Medicare Drug Price Negotiation*

The rising cost of prescription drugs has long been a concern for Medicare enrollees and for the financial health of the Medicare program. AAFA enthusiastically supports the goals of the Medicare Drug Price Negotiation Program and supports expanding Medicare’s authority to negotiate prescription drug prices.

We do urge Congress and CMS to implement appropriate oversight and regulatory mechanisms to avoid unintended consequences that could jeopardize access to medications for Medicare beneficiaries. For example, pharmacy benefit managers (PBMs) negotiate rebates with pharmaceutical companies, and in exchange, the PBMs may design drug benefits in a way that steers patients towards a particular company’s products, rather than a competitor’s products. If plans anticipate lower rebates from a drug because the price has declined, they might discourage use by assigning the drug to a higher tier with more cost sharing. Insurers may also employ prior authorization requirements and other types of utilization management to review treatment decisions made by doctors and patients—and even deny coverage for medications if not deemed necessary or cost effective.

Different asthma medications work better for some people than others. Utilization management could make it more difficult for patients to obtain the medications they and their doctors think are best. These new barriers could lead to ineffective or delayed treatment for people with asthma or apply more restrictive utilization management requirements.

To help Medicare enrollees benefit from cost savings without unintended loss of access, AAFA strongly encourages Congress and CMS to closely monitor any



proposed formulary changes from prescription drug plan sponsors. For example, CMS could specify to issuers what changes in formulary design or UM would be considered problematic, conduct specific reviews of price-negotiated drugs when reviewing annual formulary submissions, and create a portal for Medicare enrollees to report changes in access or UM requirements.<sup>13</sup>

### *Most Favored-Nation Pricing*

AAFA is deeply concerned that a Most-Favored-Nation (MFN) pricing framework fails to address the underlying complexities of the U.S. drug pricing ecosystem and risks creating unintended consequences that could restrict access for patients who rely on life-saving medications. Comparing the U.S. pharmaceutical system to those of other nations oversimplifies the reality of how drugs are developed, priced, and distributed in this country.

The U.S. has a unique health care infrastructure with many more stakeholders—including insurers, pharmacy benefit managers (PBMs), employers, and government programs—each influencing the cost patients ultimately pay. Applying international pricing models without reshaping this entire ecosystem ignores critical inefficiencies and misaligned incentives that continue to drive high costs.

Asthma medications are often used to illustrate the drug cost problem in the United States. Despite being developed decades ago, many inhalers remain costly in the U.S., often priced multiple times higher than in other high-income countries. These inflated prices are not due solely to manufacturer pricing: they reflect a complicated network of patent protections, limited competition, and opaque rebate structures that benefit stakeholders other than patients. Pegging U.S. prices to international benchmarks will not fix all of these issues.

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<sup>13</sup> Adina Lasser, “Drug Price Negotiation Requires Oversight To Protect Older Americans,” Health Affairs Forefront, January 14, 2025. Available at <https://www.healthaffairs.org/content/forefront/drug-price-negotiation-requiresoversight-protect-older-americans>



## II. Enhancing Prescription Drug Affordability

### *Out-of-Pocket Caps for Chronic Care Drugs*

AAFA supports efforts to lower patient costs through price caps in the Medicare program. Specifically, AAFA urges Congress to designate asthma inhalers as a chronic care drug category subject to a \$35 out-of-pocket cap. This model already exists in the commercial market as several manufacturers have voluntarily implemented this for select inhalers for patients with commercial insurance.

In 2024 and 2025, AstraZeneca, Boehringer Ingelheim, and GSK each voluntarily capped patient out-of-pocket costs at \$35 per month for their branded asthma inhalers, including Symbicort, Breztri, Spiriva, Advair, and Breo Ellipta. These voluntary caps, however, apply only to patients with commercial insurance or no insurance.

AAFA hears directly from patients harmed by this gap. Patients on Medicare have told AAFA they pay \$80 to \$200 or more for a single inhaler that would cost \$35 under the manufacturer programs, solely because of their coverage type. Some have been switched by their Part D plan to a different or generic inhaler that did not control their asthma as well, or have sought a formulary exception and been denied. Because asthma is a lifelong condition typically diagnosed well before retirement, patients who could once afford their prescribed inhaler under commercial insurance often find it unaffordable the moment they transition to Medicare.

AAFA urges Congress to close this gap by extending a \$35 per 30-day-supply out-of-pocket cap for asthma inhalers to Medicare Part D. That said, it is important that such caps be enacted in the context of comprehensive reforms that address the entire supply chain, from manufacturers to PBMs, to ensure sustained affordability and broader access.

### *Using Net Prices for Cost-Sharing*

Patients should not pay cost sharing based on inflated list prices. AAFA supports requiring cost-sharing to be based on **net prices**, not list prices, and establishing



accountability mechanisms for PBMs and insurers that prefer high-list-price products due to rebate structures.

### *Expanding Low-Income Subsidies and Restoring Premium Stabilization*

AAFA supports expanded eligibility for Part D Low Income Subsidies (LIS) and implementing measures to contain Part D premiums. Many families with asthma already face high costs for housing, environmental remediation, and emergency care; drug costs should not push them further into financial instability.

Meanwhile, we are deeply concerned about the President's announcement that he will be ending the Part D Premium Stabilization Demonstration, which lowered premiums for stand-alone Part D Medicare plans.<sup>14</sup> This may increase premiums for Medicare enrollees, further hindering people's ability to afford the medications they need.<sup>15</sup>

## III. Bolstering Pharmaceutical Innovation in the United States

### *Supporting Biosimilars and Generic Competition*

Generics and biosimilars offer immense value to patients and the health care system. Over the last decade, they have saved America's patients and our system more than \$3 trillion, including more than \$137 billion in savings for Medicare in 2024.<sup>16</sup> However, these savings to both patients and Medicare are at risk due to misaligned incentives

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<sup>14</sup> CMS, "Annual Release of Part D National Average Monthly Bid Amount and Other Part C & D Bid Information" (July 28, 2026). Available at <https://www.cms.gov/files/document/july-28-2026-parts-c-d-announcement.pdf>

<sup>15</sup> KFF, CMS's Decision to End Temporary Subsidies to Medicare's Stand-Alone Drug Plans Could Mean Larger Premium Increases for Some Beneficiaries Next Year (July 29, 2026). Available at <https://www.kff.org/quick-insights/cmss-decision-to-end-temporary-subsidies-to-medicare-stand-alone-drug-plans-could-mean-larger-premium-increases-for-some-beneficiaries-next-year/>

<sup>16</sup> Association for Accessible Medicines. (2024). 2024 U.S. Generic & Biosimilar Medicines Savings Report. Available at <https://accessiblemeds.org/resources/blog/2024-savings-report>



within Part D that incentivize prescription drug plans to cover higher-cost brand drugs, despite the availability of lower-cost generic and biosimilar medicines.

Biosimilars for asthma biologics have the potential to dramatically reduce costs, but only if the market is structured to support uptake. AAFA supports incentives for biosimilar development and adoption, including:

- Streamlined FDA review pathways
- Clear interchangeability standards
- Guardrails on PBM and insurer practices that block biosimilar access

Notably, generic inhalers remain rare due to device-patent barriers. AAFA urges Congress to examine reforms that would allow generic manufacturers to compete more effectively in the inhaler market.

## **Conclusion**

AAFA appreciates your leadership in addressing prescription drug pricing and welcomes continued collaboration to ensure reforms reflect the lived experiences of patients and families. Asthma and allergy patients face affordability challenges that demand targeted policy solutions. We urge Congress to adopt reforms that lower drug prices, reduce out-of-pocket costs, strengthen competition, and ensure equitable access to life-saving therapies.

AAFA stands ready to provide additional data, patient testimony, and policy expertise as the Committee advances this critical work.

Sincerely,

Kenneth Mendez  
President and Chief Executive Officer  
Asthma and Allergy Foundation of America