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Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
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Re: Guarding U.S. Medicare Against Rising Drug Costs (GUARD) Model [CMS-5546-P]

Dear Administrator Oz:

The Personalized Medicine Coalition (PMC), a multi-stakeholder group comprising nearly 200 institutions from across the health care spectrum, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Guarding U.S. Medicare Against Rising Drug Costs (GUARD) Model issued through the Center for Medicare and Medicaid Innovation (CMMI).¹ PMC and CMS share the goal of achieving better health outcomes and lowering costs for patients. However, the GUARD Model would dictate foreign price setting in Medicare, bringing with it negative consequences that pricing setting policies have had in other nations. These include reduced incentives for innovation and slower, narrower access to new treatments that could disrupt care for many American patients. PMC does not support the GUARD Model moving forward because of the impact it may have on access to personalized medicines to treat serious, rare, and chronic conditions. We strongly urge CMS to withdraw the notice of proposed rulemaking for the GUARD Model.

PMC defines personalized medicine as an evolving field in which physicians use diagnostic tests and individual details about a person's health to determine which medical treatments will work best for each patient or use medical interventions to alter molecular mechanisms that impact health. By combining data from diagnostic tests with an individual's medical history, circumstances, and values, health care providers can develop targeted treatment and prevention plans with their patients.

Personalized medicine is helping to shift the patient and provider experiences away from trial-and-error toward a more streamlined process for making clinical decisions, which leads to improved patient outcomes, a reduction in unnecessary treatment costs, and better patient and provider satisfaction. PMC and its members are leading the way in personalized medicine and in developing evidence showing how patients and the health care system can benefit from appropriate testing and tailored treatment as soon as possible during their clinical experiences.

Statement of Neutrality

Many of PMC's members will present their own responses to the Guarding U.S. Medicare Against Rising Drug Costs (GUARD) Model proposed rule and will actively advocate for those positions. PMC's comments are designed to provide feedback so that the general concept of personalized medicine can advance and are not intended to adversely impact the ability of individual PMC members, alone or in combination, to pursue separate comments with respect to the GUARD Model.

Impeding Clinical Decision Making

The transformation of health care from one-size-fits-all, trial-and-error medicine to targeted treatment utilizing each patient's molecular information continues to progress as the U.S. Food and Drug Administration (FDA) approves new personalized medicines. Since 2020, personalized medicines have accounted for at least a third of newly approved therapies each year.¹¹ In 2025 alone, fifteen of the forty-six new molecular entities approved by the FDA were personalized medicines to treat individuals with certain cancers, rare, and chronic diseases.

The GUARD Model relies in part on international price benchmarking methodologies, including Method I, which references prices in economically comparable countries. CMS describes this approach as a means of identifying lower-cost benchmarks. However, reliance on external price references functions as a structural input into coverage decision making that will have downstream effects that are not closely aligned with individual patient needs or clinical circumstances.

Personalized medicine depends on the consideration of a patient's molecular and biological characteristics and also on individual values, clinical and economic circumstances, and the potential impact of a therapy for that patient over the long term. Fundamental patient values and preferences, including the impact of treatment on quality of life, quantity vs. quality of time, functional ability related to illness or treatments, cost of supportive care, and other patient costs of treatment are weighed by patients and their caregivers. Access to appropriate therapy depends on this type of individualized clinical decision making between patients and their providers.

Personalized medicine treatment strategies create considerable benefits for patients and society since they are used in a manner that directs them toward patients who are most likely to benefit and away from those who are not. From a patient perspective, treatment value is reflected in clinical outcomes, continuity of care, and the ability to maintain effective therapy, rather than in prices established in health systems with different coverage structures and policy priorities. When pricing benchmarks like those proposed in the GUARD Model inform coverage restrictions, formulary exclusions, or coverage conditions, patients may face barriers to therapies selected based on their clinical characteristics, disease progression, or prior treatment response.

Disrupting Continuity of Care

Some patients will experience more or less benefit from a treatment than suggested by the averages reported within clinical trials and population-based data. Health care policies based on averages tend to undervalue personalized medicines because they fail to consider the full range of individual patient outcomes and benefits. Patients who rely on drugs within Medicare's protected classes often do so because they have serious, complex, or chronic conditions for which therapeutic stability is essential.

Congress established the six protected classes of drugs that Medicare Part D plans must cover to protect patient access to critical therapies. Protected class policies are intended to preserve access and continuity of care for these patients, recognizing that disruptions in therapy can have significant clinical consequences. The GUARD Model introduces financial and operational pressures that may affect plan coverage behavior, yet the proposed rule does not clearly explain how continuity of care for patients relying on protected classes will be preserved. While CMS does not propose to eliminate protected class requirements, increased reliance on coverage management tools within these classes would alter how those protections function in practice, without formally changing protected class policy. From a patient perspective, this raises concerns that safeguards designed to support stable access may be weakened through administrative or coverage-related changes rather than through formal policy modification. GUARD would subject drugs in the six protected classes to international benchmarks without any clear Congressional authorization.

In addition, the GUARD Model's use of a \$69 million spend threshold for drug inclusion creates the possibility of abrupt changes in coverage dynamics once a product crosses that threshold. For patients who have been clinically stable on a particular therapy, a shift in a drug's status under the GUARD Model may introduce new administrative requirements, formulary reassessment, or coverage conditions. Such changes can disrupt established treatment regimens and place continuity of care at risk, particularly for patients managing complex or progressive conditions. The proposed model does not provide a structural approach to preserving continuity of care for patients who are clinically stable, leaving those patients exposed to abrupt coverage changes once model thresholds are crossed.

Interrupting Innovation

Congress enacted the *Inflation Reduction Act (IRA)*, which established a framework for addressing some aspects of drug affordability in Medicare. That framework reflects policy choices aimed at generating savings and introduced a discussion of timelines that are necessary to preserve innovation, like incentives to support rare disease treatment development. PMC is concerned that layering additional pricing models like GUARD onto the *IRA* framework may have unintended consequences for patients.

Research conducted after approval of a new drug is important for advancing personalized medicine. After initial approval of a drug by the FDA, further research provides greater understanding of patients' responses to treatment based on results from molecular diagnostics. This research may lead to new or improved treatment indications that contribute to progress in personalized medicine. But smaller patient subpopulations can make it difficult to recoup investment in this research, which can require additional clinical trials. The *IRA* anticipated that the clinical and economic value of a drug could evolve over time—due to factors such as new FDA-approved indications, biosimilar entry, or shifts in real-world utilization.

The GUARD Model introduces a parallel pricing and participation structure that was not contemplated as part of the *IRA* framework and that may alter how statutory policy choices operate in practice, effectively revisiting policy tradeoffs that Congress confronted during consideration of the *IRA*. The cumulative effect of multiple, rapidly implemented reforms that interact in complex ways may result in policy overlap that reduces investment in areas of unmet medical need.

The GUARD Model’s implementation of international benchmarking may result in the United States forfeiting breakthroughs patients are waiting for. Experiences in many European systems shows that price setting policies can be accompanied by delayed drug launches or decisions not to launch at all.ⁱⁱⁱ This dynamic is especially problematic for rare disease therapies and targeted therapies, where small patient populations, high development costs, and complex manufacturing already make investments in such areas especially risky. Estimates suggest just 10 to 12 percent of drugs that reach human clinical trials become commercially available medicines.^{iv} In 2019, the Congressional Budget Office (CBO) evaluated a mandatory drug pricing proposal that relied on international benchmarking, capping drug reimbursement for certain products at 120 percent of other “wealthy nations’ pricing.” The CBO estimated that such a proposal would lead to approximately 8–15 fewer new drugs over the first decade after implementation and about thirty fewer over roughly 20 years, reflecting how reduced reimbursement is understood to reduce the number of new medicines brought to market.^v

Advances in pharmaceutical innovation over the past two decades have influenced how American patients perceive their health care. Today, patients in the United States expect not only access to cutting-edge therapies but also meaningful involvement in decisions about their care. American patients consistently report valuing access to pharmaceuticals and the autonomy to choose, alongside their providers, from available treatment options that improve their lives and the lives of their loved ones. These perspectives highlight that patients in this country prioritize both faster access to effective treatment options and the long-term health benefits those medicines deliver. This combination of expectations for innovation and preferences for personal agency in treatment decisions is part of the American context.^{vi}

In stark contrast to what American patients want, the GUARD Model could introduce practices to the United States that have resulted in slower and more limited access for patients to innovative therapies abroad. A RAND study comparing drug availability and launch timing found that new medicines are more likely to be launched first in the United States than peer wealthy nations and that the United States has a higher share of globally available new drugs than peer countries. More than half of new drugs studied were launched first in the United States, with an average lag of about one year before launch in other major markets including Australia, Canada, France, Germany, Italy, Japan, and the United Kingdom.^{vii}

Rare disease is an area where the federal government has previously implemented multiple policies to support treatment innovation. In the last five years, an increasing number of these treatments have been personalized medicines affecting small patient populations for whom the expected market return would otherwise be insufficient to justify development. CMS did not substantively address how treatments that meet the criteria of orphan drugs will be considered under the GUARD Model. Failing to account for orphan drug exclusivity periods and other incentives in the GUARD Model risks undermining the policy framework that has supported rare disease research and development for nearly four decades.

Cancer is known to be a complex disease in which the same cancer type can behave differently in different patients. The consequence of these individual responses is that within a population of patients suffering from the same cancer, mainstay therapy fails to achieve efficacy in many patients.^{viii} Personalized medicine has driven significant improvements in survival rates in recent decades, but oncology has pronounced cross-country variability in the availability and timelines of patient access. Of the seventy-four cancer drugs launched between 2011 and 2018, 95 percent are available in the United States, compared with 74 percent in the United Kingdom and 49 percent in Japan.^{ix}

Finally, the GUARD model framework is poorly suited to the rise of highly targeted, personalized therapeutics, such as genetically targeted therapies designed to influence gene expression, RNA signaling, or downstream protein production in ways that are patient specific. Their clinical value often derives from precise molecular targeting rather than broad population use, and many of these therapies are long-acting, with dosing intervals measured in months or even years. The GUARD Model attempts to develop standardized international price comparisons, but it does not account for the revenue, utilization, and lifecycle patterns of individualized therapies like genetically targeted therapies.

Conclusion

Thank you for considering these comments. PMC strongly urges CMS to withdraw the GUARD Model proposal. We look forward to serving as a resource to you and your colleagues on alternative paths that ensure sustainability of the Medicare program but maintain an ecosystem for innovation and patient access to personalized medicine. If you have any questions about the contents of this letter, please contact me at 202-499-0986 or cbens@personalizedmedicinecoalition.org.

Sincerely,



Cynthia A. Bens
Senior Vice President, Public Policy

ⁱ Centers for Medicare and Medicaid Services. *Guarding U.S. Medicare Against Rising Drug Costs (GUARD) Model; Proposed Rule.* [Docket No. CMS-5546-P]. December 23, 2025. <https://www.govinfo.gov/content/pkg/FR-2025-12-23/pdf/2025-23705.pdf> (accessed February 12, 2026).

ⁱⁱ Personalized Medicine Coalition. *Personalized Medicine at the FDA: The Scope and Significance of Progress in 2004.* https://www.personalizedmedicinecoalition.org/wp-content/uploads/2025/06/PMC_PM_at_FDA_The_Scope_Significance_of_Progress_2024_1.pdf (accessed February 12, 2026).

ⁱⁱⁱ Mulcahy Andrew, et al. *Comparing New Prescription Drug Availability and Launch Timing in the United States and Other OECD Countries*, RAND Corp. (2024), https://www.rand.org/pubs/research_reports/RRA788-4.html (accessed February 10, 2026)

^{iv} Congressional Budget Office, *Research and Development in the Pharmaceutical Industry*. April 8, 2021. <https://www.cbo.gov/publication/57126> (accessed February 12, 2026).

^v Congressional Budget Office. *Re: Effects of Drug Price Negotiation Stemming from Title I of H.R. 3.* October 11, 2019. <https://www.cbo.gov/system/files/2019-10/hr3ltr.pdf> (accessed February 12, 2026).

^{vi} Patterson, Julie, et. al. *American Patients vs Foreign Governments—A Tale of 2 Value Sets.* *The American Journal of Managed Care.* February 12, 2026. <https://www.ajmc.com/view/contributor-american-patients-vs-foreign-governments-a-tale-of-2-value-sets> (accessed February 12, 2026)

^{vii} Mulcahy Andrew, et al. *Comparing New Prescription Drug Availability and Launch Timing in the United States and Other OECD Countries.* RAND Corporation (2024). https://www.rand.org/pubs/research_reports/RRA788-4.html (accessed February 12, 2026).

^{viii} McBrearty N, Bahal D, Platero S. Fast-tracking drug development with biomarkers and companion diagnostics. *J Cancer Metastasis Treat.* 2024;10:3. <http://dx.doi.org/10.20517/2394-4722.2023.134> (accessed February 12, 2026).

^{ix} Biotechnology Innovation Organization. *Save Cures: Importing International Reference Pricing in the United States*, <https://www.bio.org/save-cures> (accessed February 12, 2026)