May 5, 2021

The Honorable Mark DeSaulnier
Chair, House Education and Labor Subcommittee on Health, Employment, Labor, and Pensions
503 Cannon House Office Building
Washington, D.C. 20515

The Honorable Rick Allen
Ranking Member, House Education and Labor Subcommittee on Health, Employment, Labor, and Pensions
570 Cannon House Office Building
Washington, D.C. 20515

Dear Chair DeSaulnier, Ranking Member Allen, and Members of the Subcommittee:

On behalf of National Taxpayers Union (NTU), the nation's oldest taxpayer advocacy organization, I wish to submit comments for the record for your May 5 hearing, "Lower Drug Costs Now: Expanding Access to Affordable Health Care." NTU has significant concerns with some provisions of the legislation the Subcommittee plans to discuss at this hearing. We wish to offer our perspective on the Lower Drug Costs Now Act (H.R. 3), while also sharing taxpayer- and market-oriented alternatives that can 1) lower prescription drug costs for patients most at need of assistance and 2) retain the robust private sector incentives that make America the world's leader in prescription drug development.[1]

NTU's Stake in Prescription Drug Policy

NTU has engaged on prescription drug policy both in Congress and in state legislatures across the country for decades. There are several reasons the nation's taxpayers can and should be concerned about federal and state prescription drug policy:

1. Federal taxpayers pay for a significant portion of the nation's prescriptions directly through the Medicaid and Medicare programs, not to mention through indirect subsidies such as premium tax credits for Affordable Care Act plans;
2. To the extent that prescription drugs save patients from more expensive medical care delivered in hospitals, clinics, and physicians' offices, proper utilization of prescription drugs (along with ongoing research and development in the private and public sectors) can actually *save* taxpayers and consumers money in the long run; and
3. America's world-leading biopharmaceutical sector creates jobs and economic growth, while offering enhanced access to new innovations and cures, that might be centered elsewhere in the world if policymakers had not so meticulously paved the way for a decades-long, productive public-private partnership that brings new treatments to American patients every year.

[1] We submitted substantially similar comments to the House Energy and Commerce Subcommittee on Health for their May 4 hearing on drug pricing legislation. For more, see: Lautz, Andrew. "House Should Avoid Punitive Taxes, Regulations on Prescription Drugs." National Taxpayers Union, May 3, 2021. Retrieved from: https://www.ntu.org/publications/detail/house-should-avoid-punitive-taxes-regulations-on-prescription-drugs

Unfortunately, some of the proposals the Subcommittee is discussing at this hearing would threaten all of the positive outcomes outlined above.

H.R. 3 Could Destroy Private-Sector Biopharmaceutical Innovation

The punitive taxes and one-sided "negotiation" process outlined in H.R. 3, the Lower Drug Costs Now Act, could destroy the private biopharmaceutical sector in the U.S., which currently leads the world. According to the Government Accountability Office (GAO): "[a]mong OECD member countries with available data, nearly two-thirds of pharmaceutical research and development [R&D] expenditures occur in the United States."[2]

The U.S. pharmaceutical industry is particularly R&D-intensive, meaning R&D expenditures make up a disproportionately large slice of the industry's net revenues. According to the Congressional Budget Office (CBO):

> In the early 2000s, when drug industry revenues were rising sharply, the industry's R&D intensity—that is, its R&D spending as a share of net revenues—averaged about 13 percent each year. Over the decade from 2005 to 2014, the industry's R&D intensity averaged 18 percent to 20 percent each year. That ratio has been trending upward since 2012, and it exceeded 25 percent in 2018 and 2019, the highest R&D intensities recorded by the pharmaceutical industry as a whole since at least 2000.[3]

This is many multiples the average R&D intensity across all industries in the U.S. Surely, one explanation for this R&D intensity is that the drugs that fail to eventually receive Food and Drug Administration (FDA) approval greatly outnumber the drugs that do receive approval. According to CBO, "[s]ome drugs developed in the preclinical phase never enter clinical trials, and of those that do, only about 12 percent reach the market (recent estimates range from 10 percent to 14 percent)."[4]

The existing policy and regulatory environment for prescription drug R&D is surely not perfect, but has by and large paved the way for a thriving, successful system that delivers new innovations to American patients on a regular basis. It has also paved the way for a large pipeline of generic alternatives to brand-name drugs, which have increased competition and lowered costs for U.S. consumers and taxpayers, all while *avoiding* harm to the numerous financial and intellectual property incentives in place for brand-name manufacturers. Indeed, nearly nine in ten prescriptions filled in the Medicare Part D program are for generic drugs.[5]

Unfortunately, H.R. 3 threatens to unravel the above system. Among the provisions that cause us deep concern are:

- Forcing the federal government to negotiate prescription drug prices for dozens of brand-name products on a nationwide basis, disrupting the current Part D system that allows privately-managed prescription drug plans and manufacturers to negotiate prices using existing tools like formulary placement, tiering, and utilization management;

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[2] Government Accountability Office. (March 2021). "Prescription Drugs: U.S. Prices for Selected Brand Drugs Were Higher on Average than Prices in Australia, Canada, and France." GAO-21-282. Retrieved from: https://www.gao.gov/assets/gao-21-282.pdf
[3] Congressional Budget Office. (April 2021). "Research and Development in the Pharmaceutical Industry." Retrieved from: https://www.cbo.gov/system/files/2021-04/57025-Rx-RnD.pdf
[4] *Id*.
[5] Medicare Payment Advisory Commission. (March 2019). "The Medicare prescription drug program (Part D): Status report." Retrieved from: http://medpac.gov/docs/default-source/reports/mar19_medpac_ch14_sec.pdf?sfvrsn=0

- Making the negotiation process severely one-sided, by punishing manufacturers with an up to 95-percent excise tax on *gross sales* of a given product should they fail to agree to the government-set price for a drug; this effectively turns the so-called "negotiation" between Medicare and manufacturers into an extortion by the federal government;
- Rigging the "negotiation" from the start with a maximum price that is tied to the average pricing for a prescription drug in foreign countries that, by and large, have centralized, government-set prices; and
- Allowing private payers, such as health insurers and self-funded plans, automatic access to the government-set price, rather than retaining the existing system where manufacturers and payers negotiate prices as market actors; and
- Punishing *all* manufacturers, brand and generic, with a mandatory rebate -- which could fairly be called a tax -- if they raise prices faster than inflation.

For all these reasons and more, we believe that Congress should not pass H.R. 3 under any circumstances. While portions of the legislation, such as the Medicare Part D redesign and an out-of-pocket cap for seniors, are worthy of further consideration, those worthy provisions cannot and should not be considered in tandem with the punitive taxes that dominate the Lower Drug Costs Now Act.

Pro-Taxpayer and Pro-Market Alternatives

Many Americans still do struggle with their prescription drug costs. We recognize it is not enough to oppose the policies the Subcommittee is considering at its hearing *without* offering up alternatives.

NTU offered its lengthy thoughts on this matter in a February issue brief, "A Taxpayer- and Market-Oriented Path Forward for Federal Prescription Drug Policy."[6] We humbly ask you to consider our policy alternatives, which we summarize below:

- Capping the amount seniors pay out of pocket in Part D for the first time (and paying for these changes by reducing taxpayer liability in the so-called "catastrophic" phase of the Part D benefit where drug spending is highest);
- Actually reducing distortionary rebates in the Medicaid, Part D, and 340B Drug Pricing programs, where steep, mandatory discounts on the cost of brand-name drugs push the cost bubble for prescription drugs onto other payers, like employers, private health insurers, and private plan sponsors in Part D;
- Using America's free trade negotiations with foreign partners to reduce price controls and price fixing in other countries; steep, mandatory discounts manufacturers must provide in other countries pushes the cost bubble for drug R&D, manufacturing, and distribution onto Americans; and
- Reducing regulatory barriers to competition and patient barriers to access; though the NTU team does not weigh in on the intricacies of Food and Drug Administration (FDA) policy, we are concerned by the numerous complaints from governmental and non-governmental stakeholders that the FDA drug approval process is too costly, too time-consuming, and too burdensome.[7]

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[6] Lautz, Andrew. "A Taxpayer- and Market-Oriented Path Forward for Federal Prescription Drug Policy." National Taxpayers Union, February 25, 2021. Retrieved from: https://www.ntu.org/publications/detail/a-taxpayer-and-market-oriented-path-forward-for-federal-prescription-drug-policy

[7] Sepp, Pete. "Prescription Drug Costs: Better Ways to Help Patients and Taxpayers." National Taxpayers Union, December 6, 2018. Retrieved from: https://www.ntu.org/publications/detail/prescription-drug-costs-better-ways-to-help-patients-and-taxpayers

Thank you for considering our viewpoints on these critical issues. Should you be interested in engaging on any of the above proposals or should you have any questions, we are at your disposal.

Sincerely,

Andrew Lautz
Director of Federal Policy

CC: The Honorable Bobby Scott, Chair, House Committee on Education and Labor
The Honorable Virginia Foxx, Ranking Member, House Committee on Education and Labor
Members of the House Education and Labor Subcommittee on Health, Employment, Labor, and Pensions