The Center for Healthcare Affordability

A Project of the Institute for Legislative Analysis

August 17, 2026

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Re: Comments of the Center for Healthcare Affordability on the "Commonsense Policy Options to Lower Drug Prices for Patients"

Dear Ranking Member Wyden,

On behalf of the Center for Healthcare Affordability (CHA), thank you for the opportunity to provide comments in response to the Senate Finance Committee Minority Staff's *Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients*.

CHA is a project of the Institute for Legislative Analysis, and serves as a national healthcare policy research initiative focused on developing market-oriented solutions that improve affordability, competition, innovation, and patient access. CHA maintains an extensive healthcare policy database and has developed a comprehensive Healthcare Reform Prescriptions framework examining five of the most significant challenges affecting healthcare affordability in the United States.[1]

Prescription drug policy sits at the intersection of two of those challenges: Rising Medical Treatment Costs and Stagnating Advancements in Healthcare. CHA has already engaged extensively on these issues through its public policy framework, including proposals to reform pharmacy benefit managers (PBMs), increase price transparency, facilitate direct-to-consumer purchasing, end foreign free-riding on American pharmaceutical innovation, preserve strong intellectual property protections, reform the 340B program, and reduce the regulatory cost and uncertainty associated with developing new treatments.[2]

Center for Healthcare Affordability
300 Independence Ave, S.E.
Washington, D.C. 20003

It is from that established framework, rather than the interests of any single healthcare stakeholder, that CHA evaluates the proposals contained in this RFI.

CHA agrees with an important premise underlying the Committee's work: prescription drug affordability cannot be evaluated solely by looking at manufacturer list prices. Patients encounter a complex supply chain involving manufacturers, wholesalers, PBMs, insurers, pharmacies, hospitals, physicians, and government payment systems, each of which can introduce incentives that distort prices or separate the amount a patient pays from the actual net cost of a medicine.

For that reason, CHA supports several concepts contained in Sections II and III of the RFI. We believe those reforms deserve serious consideration. At the same time, several of the proposals in Section I would significantly expand government price setting, including through international reference pricing, earlier and broader Medicare price negotiation, expanded inflation rebates, and potential federal intervention in launch prices. Those policies conflict with the RFI's stated objective of strengthening American biopharmaceutical innovation.

Areas of Agreement: Restoring Competition and Correcting Supply Chain Distortions

CHA appreciates that the RFI recognizes the role of PBMs, insurers, vertically integrated healthcare companies, and other intermediaries in determining what patients ultimately pay for prescription medicines.

CHA strongly supports removing contractual barriers that prevent direct negotiation between manufacturers and health plans. The RFI specifically asks whether Congress should prohibit or restrict PBM contract provisions that make the PBM the “exclusive negotiator” or prevent manufacturers from offering discounts directly to health plans. CHA believes such restrictions are anti-competitive and should generally be prohibited. Our Healthcare Reform Prescriptions framework similarly calls for removing contracting barriers that prevent manufacturers, patients, employers, and plans from bypassing unnecessary intermediaries and entering into more transparent purchasing arrangements.[3]

Congress should encourage competition among purchasing models, not protect a system in which a dominant intermediary can contractually prevent its customer from seeking a better price elsewhere.

CHA also supports basing patient cost sharing more closely on the actual net price of a medicine. The RFI correctly observes that manufacturer rebates and discounts are frequently not reflected when patient coinsurance is calculated. As a result, a patient can be charged cost sharing based on a substantially higher price than the amount ultimately borne by the health plan.

If an insurer or PBM receives a significant discount on a medicine, the patient purchasing that medicine should be among the primary beneficiaries of that discount. CHA's framework calls for passing rebates through to consumers and restoring transparent price signals at the pharmacy counter.[3] Reform in this area would provide patient relief without imposing a federal ceiling on the underlying market price.

CHA supports greater scrutiny of PBM-owned private-label products, vertical integration, and self-dealing. The Federal Trade Commission has reported that the three largest PBMs and their affiliated pharmacies generated more than $7.3 billion in dispensing revenue above estimated acquisition costs on the specialty generic drugs examined between 2017 and 2022, including extraordinarily large markups on certain medicines.[4] Congress should require meaningful disclosure of acquisition costs, spreads, related-party transactions, and formulary incentives involving affiliated entities.

CHA would distinguish such transparency requirements from a federally mandated "cost-plus" price ceiling. Disclosure can expose self-dealing and allow purchasers to respond through competition. Federal price setting simply substitutes one distortion for another.

CHA is also open to reforming price-linked compensation under Medicare Part B. The current ASP-plus-percentage structure can cause the dollar value of a physician's add-on payment to increase when the underlying drug price increases. A payment system that adequately compensates physicians for acquisition, handling, storage, administration, and financial risk without making compensation mechanically dependent upon the drug's price could improve neutrality.[5] Any reform must protect smaller and rural practices that may acquire medicines above ASP and should not inadvertently push physician-administered care into higher-cost hospital settings.

Similarly, CHA supports greater transparency concerning inappropriate pharmacy claim rejections and more efficient beneficiary appeals. Utilization management can serve legitimate purposes, but plans should be accountable when medically appropriate prescriptions are repeatedly denied and those denials are subsequently overturned.

Finally, **CHA strongly supports the RFI's interest in reducing the cost and complexity of clinical trials in the United States.** Proposals to reduce duplicative Institutional Review Board processes, expand the number of community providers capable of serving as clinical trial sites, facilitate patient participation, and streamline regulatory processes align closely with CHA's existing recommendations for FDA reform. CHA has specifically called for wider use of adaptive and pragmatic trials, real-world evidence, community-based research, measurable FDA review benchmarks, and other reforms that reduce development time without sacrificing patient safety.[6]

These reforms demonstrate an important point: Congress can lower healthcare costs by making markets work better rather than by administratively determining prices.

Government Price Controls and the Economics of Medical Innovation

CHA respectfully disagrees with the RFI's repeated characterization of pharmaceutical profitability as evidence of a market failure requiring government price intervention.

Many of America's major pharmaceutical manufacturers are publicly traded companies. Smaller biotechnology companies commonly rely on venture capital, private equity, public equity markets, licensing arrangements, or partnerships with larger manufacturers. These companies do not operate in a separate pool of capital reserved for biomedical research. They compete for investment against every other potential use of capital in the economy.

That distinction is fundamental to sound drug pricing policy.

The RFI itself acknowledges the extraordinary economics of pharmaceutical development. It states that drug development typically requires 10 to 15 years, can cost hundreds of millions or billions of dollars, and carries an approximately **90 percent failure rate even among candidates that reach clinical trials.** The RFI further observes that smaller biotechnology companies are frequently funded by venture capital and that larger pharmaceutical manufacturers must "secure predictable quarterly returns for shareholders" while managing diversified development pipelines.[7]

Those facts should inform the Committee's analysis of every price-control proposal in Section I.

Profitability is not incidental to this process. It is what makes accepting the risk economically possible.

A successful medicine must generate returns not merely against the manufacturing cost of that particular product, but against the cost of the scientific programs, compounds, clinical trials, and investments that never resulted in an approved medicine. CBO has specifically cautioned that short-term comparisons of pharmaceutical profit margins can provide an incomplete picture because long-term profitability must account for the development costs and opportunity costs associated with an entire portfolio of successful and unsuccessful projects. CBO notes that investment capital committed to pharmaceutical R&D could instead be invested in less risky activities and that investors therefore require greater potential returns as compensation for accepting drug-development risk.[8]

This is not a moral defense of any particular drug price or corporate profit margin. It is the basic mechanics of capital allocation.

CBO has repeatedly concluded that expected future revenue is a central determinant of pharmaceutical R&D investment. When expected prices and profits decline, R&D investment falls and fewer new medicines are developed. CBO's more recent analysis similarly concludes that policies reducing manufacturers' expected future revenue will

diminish incentives for private applied research and that larger reductions in expected revenue will produce larger effects on innovation.[9]

Government price controls therefore do not simply redistribute profits from an existing medicine. They alter the expected return calculation for medicines that do not yet exist.

The treatment most endangered by an overly aggressive price-control regime is often not the medicine already sitting on the pharmacy shelf. It is the Alzheimer's compound, antibiotic, rare-disease therapy, gene therapy, or other high-risk candidate that never receives the next round of financing because the prospective return no longer compensates investors for the probability of failure.

The Committee's goals of making medicines more affordable today and producing lifesaving medicines tomorrow are both legitimate. Policy must recognize, however, that these objectives can come into conflict when government attempts to reduce prices by suppressing the return on successful innovation.

Section I: Proposals to Lower Manufacturer Prices

International Reference Pricing and Most Favored Nation Policies

Of the proposals contained in the RFI, CHA is most concerned about the potential incorporation of international reference pricing into Medicare.

CHA strongly opposes mandatory Most Favored Nation or international reference pricing policies, regardless of the political party or presidential administration proposing them.

The RFI contemplates adding a third ceiling to Medicare's negotiation program based on a percentage of an international reference price, potentially using prices from countries such as Australia, Canada, France, Germany, Japan, and the United Kingdom. It also considers reducing otherwise applicable Medicare ceilings when they substantially exceed a foreign benchmark.[10]

Both approaches suffer from the same fundamental problem: **they allow foreign governments to influence the price of medicines in the United States.**

Prices in many reference countries are not the product of ordinary competitive markets. They are substantially influenced by centralized government reimbursement systems, budget constraints, health technology assessments, mandatory rebates, access restrictions, and other government interventions. Importing the resulting number into American law does not import “competition.” It imports the outcome of another government's price-control system.

The RFI itself identifies another serious weakness. Foreign net prices are frequently obscured by confidential rebate arrangements. Germany, for example, has taken steps that allow confidential discounts to remain hidden from countries applying international reference pricing. The RFI consequently acknowledges that the foreign pricing information available to the federal government may differ materially from the actual net price paid abroad and that smaller reference baskets could be manipulated. [10]

Congress should be especially reluctant to establish a statutory U.S. pricing mechanism using data that it knows may be incomplete.

More fundamentally, international reference pricing approaches the global free-rider problem from the wrong direction.

CHA agrees that it is unfair for American patients to finance a disproportionate share of the world's pharmaceutical innovation while wealthy foreign countries suppress the prices they pay. Our Healthcare Reform Prescriptions framework explicitly identifies ending global free-riding as a major reform priority.[11] The appropriate response, however, is to pressure wealthy trading partners to contribute more toward the cost of developing innovative medicines, not to import their price controls into the American healthcare system.

Current U.S. trade policy provides a particularly clear illustration. In June 2026, the Office of the United States Trade Representative initiated a Section 301 investigation into Germany's "persistent underpayment" for innovative pharmaceutical products. USTR specifically stated that Germany's policies may result in Americans bearing a disproportionate share of pharmaceutical R&D costs.[12]

At the same time, the recently concluded U.S.-United Kingdom pharmaceutical arrangement requires the United Kingdom to increase the net price paid by the NHS for prospective new medicines by 25 percent, increase spending on new medicines as a percentage of GDP, and modify other reimbursement policies in exchange for U.S. trade concessions.[13]

That is the correct direction of travel.

It would be fundamentally contradictory for the United States to tell Germany through trade policy that its suppressed pharmaceutical prices are unreasonable and contribute too little toward global innovation, while simultaneously instructing Medicare to use those same suppressed German prices as a benchmark for what Americans may pay.

Congress should push foreign prices upward toward a fairer contribution to global R&D, not pull American prices downward toward government-controlled foreign levels.

This distinction is particularly important because the RFI acknowledges that the United States is by far the world's most important pharmaceutical market and accounted for 62.4 percent of pharmaceutical sales among OECD countries in 2022 despite representing only 23.8 percent of volume. The RFI itself therefore concedes that U.S. pricing policies are likely to have a disproportionately large effect on future innovation.[10]

CHA urges the Committee to reject statutory international reference pricing and instead work with USTR and other federal agencies on a sustained trade strategy that challenges foreign price suppression, strengthens intellectual property protection, and increases wealthy countries' financial contribution to pharmaceutical innovation.

Expanding Medicare Negotiation to More Drugs and Earlier in the Product Lifecycle

CHA also opposes proposals to give the Secretary open-ended authority to subject additional medicines to Medicare price negotiation and to move negotiation substantially earlier in a product's lifecycle.

The existing timelines are not arbitrary. As the RFI acknowledges, delaying government negotiation provides manufacturers a period in which to attempt to recoup development costs and earn a return sufficient to preserve future investment incentives.[14]

Shortening that period changes the expected value of a drug long before the drug is approved.

This is particularly consequential for small-molecule research, follow-on indications, and investments in areas with long clinical development timelines. Investors evaluating an asset today must estimate what the commercial opportunity may look like ten or fifteen years into the future. If Congress repeatedly changes the point at which government-administered pricing begins, that political risk becomes part of every present-day investment decision.

CBO's analysis confirms the direction of the effect. Policies that reduce expected future pharmaceutical revenue reduce the expected return to R&D and ultimately reduce the number of new medicines brought to market.[9]

CHA does support efforts to make biosimilar competition faster and more effective. The RFI identifies several potentially constructive concepts, including faster issuance of billing codes and possible reductions in mandatory government discounts that can inhibit biosimilar entry. Such pro-competition reforms should move forward on their own merits. Congress should not first shorten the period for innovators to receive market returns and then attempt to repair the resulting damage with a new layer of federal subsidies or incentives.

Incentives for Orphan and Rare-Disease Development

CHA opposes replacing the orphan drug protections recently enacted in H.R. 1 with the framework contemplated by the *No Big Blockbuster Bailouts Act*.

Rare-disease drug development presents unusually difficult economics. Patient populations are small, clinical recruitment can be challenging, scientific uncertainty is often substantial, and development costs do not necessarily decline in proportion to the number of potential patients.

Congress should also avoid treating the development of additional indications as evidence of manipulation. Testing an approved medicine in an additional rare disease can require new research, clinical trials, regulatory submissions, and considerable investment. Policies that cause a successful orphan medicine to lose pricing protection as additional uses are discovered can unintentionally discourage precisely the follow-on research Congress should want manufacturers to undertake.

A Medicare spending threshold is also an imperfect proxy for excessive profitability. High aggregate spending can reflect clinical value, disease severity, small populations with substantial per-patient treatment costs, or the absence of alternative therapies. It does not by itself demonstrate economic rents or abuse.

CHA therefore supports maintaining predictable orphan drug incentives while pursuing competition where meaningful therapeutic alternatives exist.

Inflation Rebates and Expansion Into the Commercial Market

CHA strongly opposes proposals to rebase Medicare inflation rebates to an earlier year or extend Medicare's inflation-rebate framework into the commercial insurance market.

These mechanisms operate as government price-growth caps. Once a manufacturer becomes liable for a statutory payment whenever its price exceeds a federally selected benchmark, the economic distinction between a rebate and a price control becomes largely semantic.

Extending the framework to commercial units would be particularly problematic. The RFI itself contemplates applying the inflation-rebate mechanism broadly beyond Medicare.[15] Such an expansion would transform what was enacted as a federal entitlement-program policy into a nationwide government rule governing price growth in employer and commercial insurance markets.

That would represent a major federal intrusion into private contracting.

It could also create counterproductive incentives. Manufacturers that expect future price increases to be constrained by a statutory baseline have a stronger incentive to

account for that constraint when establishing an initial price. Rebasing the formula backward compounds the problem by attaching future financial consequences to prices established before the new policy was known.

CBO has examined commercial-market inflation rebates and estimated that they would produce only a small reduction in average prescription drug prices, while also reiterating that policies reducing expected manufacturer revenue make pharmaceutical R&D less attractive.[16]

Congress should not federalize commercial pharmaceutical pricing in exchange for modest projected price effects and uncertain long-term innovation losses.

Subscription Models

CHA does not oppose subscription-based contracting as a concept. A manufacturer and payer may rationally agree to a fixed or population-based payment structure when predictable revenue, broader utilization, and lower unit costs can create value for both parties.

Indeed, voluntary innovative contracting is exactly the kind of experimentation a market-oriented system should permit.

CHA would oppose, however, making participation compulsory for private health plans, financing such a program through mandatory plan assessments, or using a federally established subscription price as another mechanism for government price setting. The RFI expressly asks whether participation should be mandatory and whether member-weighted assessments should finance such arrangements.[17]

Congress should remove legal and regulatory obstacles to voluntary value-based and subscription agreements, then allow manufacturers, employers, insurers, and other purchasers to determine whether those models work for them.

Launch Prices

CHA is not against reasonable transparency surrounding manufacturer pricing decisions but **would strongly oppose a federal launch-price ceiling, mandatory "cost-effectiveness" benchmark**, or penalty imposed merely because the government concludes that an initial price is too high.

The RFI cites cost-effectiveness analysis in asking how Congress might address allegedly excessive launch prices.[18] That approach risks converting a disclosure policy into a federal valuation regime.

Launch-price statistics must also be interpreted carefully. An increasing proportion of new therapies target rare diseases, small patient populations, advanced cancers, or highly specialized conditions. The annual price of a medicine is not, standing alone, a measure of its profitability, value, or development cost.

Government does not possess the information necessary to determine the "correct" price for a novel therapy. The better discipline is competition, rapid entry of therapeutically competing products, strong generic and biosimilar pathways, transparent purchasing, and policies that give patients and payers greater ability to compare alternatives.

Section II: Patient Affordability and Supply Chain Reform

CHA shares the Committee's concern about high out-of-pocket costs, but broad statutory cost-sharing caps should not become the default response to affordability problems.

A cap can reduce the amount one patient pays at the pharmacy counter, but it does not eliminate the underlying cost. The remaining expense is transferred elsewhere in the system, potentially through higher premiums, taxpayer spending, narrower formularies, or other forms of utilization management.

For highly rebated drugs, a more direct solution is to ensure that patients benefit from the rebates and discounts already being generated on their prescriptions. CHA therefore believes the RFI's proposal to calculate applicable patient cost sharing using net prices is a more market-oriented and sustainable approach than layering additional product-specific caps onto Medicare.

Similarly, CHA would approach expansion of the Part D Low-Income Subsidy with caution. Assistance for genuinely low-income beneficiaries is more defensible than universal price caps, but increasing eligibility to 200 percent of the federal poverty level while eliminating the asset test would expand federal entitlement obligations at a time when the system is already facing enormous unfunded liabilities.

CHA supports expanded reporting of NADAC and other acquisition-cost information for generic drugs because transparent acquisition data can expose excessive spreads and improve negotiations. We do not support turning NADAC into a federal maximum price. Private cash-pay and cost-plus pharmacies have demonstrated that alternative distribution models can compete effectively on generic prices. Congress should make it easier for patients to use those alternatives, including by eliminating benefit-design and contracting rules that penalize cash purchasing, rather than nationalizing the underlying pricing formula.

On Part D premiums, **CHA opposes permanently extending temporary premium stabilization subsidies** or simply shifting additional catastrophic liability onto

manufacturers as a substitute for structural reform. Technical modifications to risk adjustment and the relationship between stand-alone PDP and MA-PD bidding should be evaluated for actuarial neutrality and competition, not used to conceal the premium effects of other federal mandates.

CHA also opposes a federal minimum dispensing-fee mandate. Independent pharmacies face legitimate pressures, including PBM steering, below-cost reimbursement, and vertically integrated competitors. Those problems warrant transparency and competition enforcement. A federally imposed minimum price for pharmacy services, however, is itself a price floor and risks institutionalizing higher costs rather than addressing the underlying contracting practices.

Taken together, these positions demonstrate why **CHA believes the Committee's strongest Section II proposals are those aimed at competition and transparency**: ending PBM gag clauses, exposing affiliate spreads, passing discounts through to patients, improving claims accountability, reforming distorted percentage-based compensation, and enabling direct contracting.

Section III: Strengthening American Biopharmaceutical Innovation

CHA strongly shares the RFI's goal of preserving America's global leadership in biomedical innovation. We differ primarily on how Congress should accomplish that objective.

The most durable innovation policy is to lower the cost, time, and regulatory risk of developing a medicine.

CHA therefore supports reforms that make clinical trials more efficient, expand trial participation, reduce unnecessary IRB duplication, enable more community-based research, improve the use of real-world evidence, and accelerate FDA decision-making while maintaining rigorous safety standards.[6]

CBO's research underscores the importance of regulatory time. It estimates that even a hypothetical nine-month increase in FDA review times would increase development costs enough to eventually reduce annual drug approvals by roughly 2 percent.[19] The reverse lesson is important: reducing unnecessary delay can improve expected returns without raising patient prices or creating a new federal subsidy.

CHA would oppose creating a new industry assessment to finance NIH research, as the RFI specifically asks whether Congress should create a new funding stream for NIH through an assessment on the pharmaceutical industry.[20]

That proposal in fact illustrates the internal tension within the RFI.

Congress should not reduce the return on pharmaceutical investment through expanded price controls in Section I, impose an additional industry assessment in Section III, and then attempt to replace the private investment discouraged by those policies with government-directed research funding.

If Congress believes additional taxpayer support for basic research is warranted, that funding should be debated transparently through the regular appropriations process and prioritized against existing federal expenditures. It should not be financed through an off-budget levy on the same innovation ecosystem Congress says it wants to strengthen.

CHA likewise urges caution toward proposals modeled on the CHIPS and Science Act that would create a permanent pharmaceutical industrial-policy apparatus, select favored therapeutic areas, subsidize particular firms, or condition government support on weakened patent rights.

Public policy should establish a favorable environment for innovation, not ask federal officials to choose which technologies, companies, or diseases are most deserving of investment.

That means protecting intellectual property, maintaining predictable tax treatment for R&D, reducing regulatory barriers, strengthening the domestic scientific workforce, ensuring timely FDA and CMS decisions, and addressing foreign practices that diminish the returns available for American innovation.

The RFI itself recognizes that China is rapidly increasing its share of the global biopharmaceutical pipeline and clinical trial activity.[21] The United States should take that competitive threat seriously. Weakening the expected return on American pharmaceutical innovation while China aggressively seeks to attract scientific capital would be a particularly dangerous policy combination.

Conclusion

CHA appreciates the breadth of the Committee's RFI and agrees that patients deserve a prescription drug market that is more transparent, competitive, and affordable.

Several proposals deserve bipartisan consideration. Congress should eliminate PBM contracting provisions that prevent direct price competition, ensure patients benefit from discounts generated by their prescriptions, scrutinize self-dealing among vertically integrated PBMs and pharmacies, improve accountability for inappropriate prescription denials, reconsider percentage-based payment incentives, and reduce the cost and complexity of conducting clinical trials in the United States.

Those reforms address genuine distortions without requiring Washington to determine the price of a medicine.

CHA respectfully urges the Committee to reject the RFI's expansion of government price controls, including mandatory international reference pricing, broader and earlier Medicare negotiation, commercial-market inflation rebates, administrative launch-price constraints, mandatory subscription arrangements, and new industry assessments.

Most importantly, Congress should distinguish between ending foreign free-riding and importing foreign price controls. CHA strongly supports the former and strongly opposes the latter. The United States should use trade negotiations, intellectual property protections, and other tools to require wealthy foreign countries to contribute more fairly to the cost of pharmaceutical innovation. It should not reward those countries' price suppression by writing their government-controlled prices into American law.

America's pharmaceutical innovation ecosystem succeeds because scientists, entrepreneurs, biotechnology startups, established manufacturers, and investors are willing to accept extraordinary uncertainty in pursuit of medical breakthroughs. Government cannot eliminate that risk. It can only determine whether the potential return remains sufficient for private capital to bear it.

The better path to affordable medicines is therefore not to suppress the reward for successful innovation, but to remove the distortions that make healthcare unnecessarily expensive.

Thank you for the opportunity to provide comments on these important issues.

Sincerely,

Fred McGrath
Executive Director, Center for Healthcare Affordability
A Project of the Institute for Legislative Analysis

Endnotes:

1. Center for Healthcare Affordability: Healthcare Reform Prescriptions
2. Center for Healthcare Affordability: Rising Medical Treatment Costs and Stagnating Advancements in Healthcare
3. Center for Healthcare Affordability: Healthcare Reform Prescriptions — PBM Reform and Direct Purchasing
4. FTC: Report on Prescription Drug Middlemen and Specialty Generic Drug Markups
5. Senate Finance Committee: Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients — Medicare Part B Payment Reform
6. Center for Healthcare Affordability: Healthcare Reform Prescriptions — FDA and Clinical Trial Reform
7. Senate Finance Committee: Request for Information: Drug Development Costs, Failure Rates, Venture Capital, and Pharmaceutical Investment
8. CBO: Prescription Drugs: Spending, Use, and Prices
9. CBO: Research and Development in the Pharmaceutical Industry; Alternative Approaches to Reducing Prescription Drug Prices
10. Senate Finance Committee: Request for Information — International Reference Pricing and Most Favored Nation Proposals
11. Center for Healthcare Affordability: Healthcare Reform Prescriptions — Ending Global Free-Riding
12. USTR: Section 301 Investigation of Germany's Underpayment for Innovative Pharmaceutical Products
13. USTR: U.S.-United Kingdom Arrangement on Pharmaceutical Pricing
14. Senate Finance Committee: Request for Information — Expansion and Timing of Medicare Drug Price Negotiation
15. Senate Finance Committee: Request for Information — Medicare and Commercial Market Inflation Rebates
16. CBO: Alternative Approaches to Reducing Prescription Drug Prices
17. Senate Finance Committee: Request for Information — Prescription Drug Subscription Models
18. Senate Finance Committee: Request for Information — Prescription Drug Launch Prices
19. CBO: How Changes to NIH Funding and FDA Review Times Would Affect the Development of New Drugs
20. Senate Finance Committee: Request for Information — Potential Pharmaceutical Industry Assessment to Fund NIH Research
21. Senate Finance Committee: Request for Information — U.S. Biopharmaceutical Competitiveness and China