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# EXAMINING FDA'S GENERIC DRUG AND BIOSIMILAR USER FEE PROGRAMS

## HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

MARCH 2, 2017

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[1] The committee did not receive a response from Dr. Woodcock by the time of printing.
[2] The committee did not receive a response from Mr. Gaugh by the time of printing.
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[4] The committee did not receive a response from Mr. Leicher by the time of printing.
[5] The committee did not receive a response from Ms. Holcombe by the time of printing.

# EXAMINING FDA'S GENERIC DRUG AND BIOSIMILAR USER FEE PROGRAMS

**THURSDAY, MARCH 2, 2017**

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
*Washington, DC.*

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123 Rayburn House Office Building, Hon. Michael Burgess (chairman of the subcommittee) presiding.

Present: Representatives Burgess, Guthrie, Lance, Griffith, Bilirakis, Long, Bucshon, Mullin, Collins, Carter, Walden (ex officio), Green, Engel, Schakowsky, Butterfield, Matsui, Castor, Sarbanes, Schrader, Kennedy, Cardenas, Eshoo, DeGette, and Pallone (ex officio).

Also present: Representative Welch.

Staff present: Mike Bloomquist, Deputy Staff Director; Karen Christian, General Counsel; Jordan Davis, Director of Policy and External Affairs; Paige Decker, Executive Assistant and Committee Clerk; Paul Edattel, Chief Counsel, Health; Blair Ellis, Digital Coordinator/Press Secretary; Adam Fromm, Director of Outreach and Coalitions; Jay Gulshen, Legislative Clerk, Health; Zach Hunter, Director of Communications; Katie McKeough, Press Assistant; Carly McWilliams, Professional Staff Member, Health; Alex Miller, Video Production Aide and Press Assistant; Dan Schneider, Press Secretary; Danielle Steele, Policy Coordinator, Health; John Stone, Senior Counsel, Health; Josh Trent, Deputy Chief Health Counsel, Health; Hamlin Wade, Special Advisor, External Affairs; Luke Wallwork, Staff Assistant; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Dan Miller, Minority Staff Assistant; Olivia Pham, Minority Health Fellow; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; Kimberlee Trzeciak, Minority Health Policy Advisor; and C. J. Young, Minority Press Secretary.

## OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I want to welcome everyone to the subcommittee hearing, and I ask that all guests take their seats and the subcommittee will now come to order. The chair recognizes himself for 5 minutes for the purpose of an opening statement.

Today's hearing marks the Health Committee's first public discussion on the reauthorization of several key user fee programs at

the United States Food and Drug Administration. This hearing will focus on the generic drug and biosimilar user fee programs, and we will turn our attention to the reauthorization of the Prescription Drug User Fee Act and the Medical Device User Fee Amendments later this month. All four of these programs will expire in September, and thus must be reauthorized for fiscal years 2018 through 2022. Chairman Walden and I are committed to moving the user fee legislation through committee following regular order, with time to spare.

I want to welcome Dr. Woodcock back to the subcommittee. I would also like to commend the Food and Drug Administration and industry for the various briefings that they have provided members and members' staffs throughout the negotiation process and for transmitting the proposed agreements to Congress in a timely manner pursuant to the process laid out in statute.

Committee staff has been working on a bipartisan basis with the Senate Health Committee to review the agreements in detail and to develop the necessary authorizing language for consideration. I appreciate the technical assistance that the Food and Drug Administration has provided, not to mention the expertise of our legislative counsels. It is because of these efforts that we are well on track for a timely reauthorization.

Since 1992, with the initial authorization of the Prescription Drug User Fee Act, revenues generated from regulated industry fees have supplemented congressional appropriations and significantly enhanced the Food and Drug Administration's ability to review product applications and a more predictable manner.

Based in large part on the success of the Prescription Drug User Fee Act, medical device user fees were authorized in 2002, followed by Generic Drug User Fee Amendments of 2012, and the Biosimilar User Fee Act of 2012, both of which are the focus of today's hearing. I look forward to learning more about their implementation to date, and ways to improve these important programs going forward.

Approval of additional biosimilars will undoubtedly increase competition in a complex and often costly biologic drug market. Small-molecule generics already account for billions of dollars in savings each year. Nonetheless, for a variety of reasons, generic competition is lacking for certain products despite the absence of patent protection. We will hear from the Food and Drug Administration and from industry about how improving and reauthorizing the Generic Drug User Fee Amendments will help to close those gaps.

We will also hear from our colleagues, Kurt Schrader from Oregon and Gus Bilirakis from Florida, about H.R. 749, the Lower Drug Costs through Competition Act, a bill that they recently introduced along with a bipartisan number of cosponsors. H.R. 749 aims to encourage market entry by generic manufacturers in situations where it may not otherwise make sense from a business perspective.

I understand that introduction of this bill has led to a robust discussion about additional and alternative ways to spur such competition. That is a good thing. I appreciate the sponsors' willingness to hear from a variety of stakeholders and to work with bipartisan committee staff to improve the bill prior to proceeding to markup.

Again I want to welcome all of our witnesses here today. I apologize for the late start. Thank you for being with us, and look forward to your testimony. The chair now recognizes the ranking member of the subcommittee, Mr. Green from Texas, 5 minutes for an opening statement, please.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

The Subcommittee will come to order.

The Chair will recognize himself for an opening statement.

Today's hearing marks the Health Subcommittee's first public discussion on the reauthorization of several key user fee programs at the U.S. Food and Drug Administration (FDA). This hearing will focus on the generic drug and biosimilar user fee programs and we will turn our attention to reauthorization of the Prescription Drug User Fee Act (PDUFA) and the Medical Device User Fee Amendments (MDUFA) later this month. All four of these programs expire in September and must be reauthorized for Fiscal Years 2018–2022. Chairman Walden and I are committed to moving the user fee legislation through Committee, following regular order, with ample time to spare.

I want to welcome Dr. Woodcock back to this Subcommittee. I would also like to commend the FDA and industry for the various briefings they provided our members' staffs throughout the negotiation process, and for transmitting the proposed agreements to Congress in a timely manner pursuant to the process laid out in statute. Committee staff has been working on a bipartisan basis with the Senate HELP Committee to review the agreements in detail, and develop the necessary authorizing language for our consideration. I appreciate the technical assistance FDA has provided, not to mention the expertise of our legislative counsels. It because of these efforts that we are well on track for a timely reauthorization.

Since 1992, with the initial authorization of PDUFA, revenues generated from regulated industry fees have supplemented Congressional appropriations and significantly enhanced FDA's ability to review product applications in a more efficient and predictable manner. Based in large part on the success of PDUFA, medical device user fees were authorized in 2002, followed by the Generic Drug User Fee Amendments of 2012 (GDUFA), and the Biosimilar User Fee Act of 2012 (BsUFA)-both of which are the focus of today's hearing. I look forward to learning more about their implementation to date and ways to improve these important programs going forward.

Approval of additional biosimilars will undoubtedly increase competition in the complex and often costly biological drug market. Small molecule generics already account for billions of dollars in savings each year. Nonetheless, for a variety of reasons, generic competition is lacking for certain drug products, despite the absence of patent protection. We will hear from FDA and industry about how improving and reauthorizing GDUFA will help close these gaps.

We will also hear from our colleagues Kurt Schrader (D–OR) and Gus Bilirakis (R–FL) about H.R. 749, the Lower Costs Through Competition Act-a bill they recently introduced along with a bipartisan roster of co-sponsors. H.R. 749 aims to encourage market entry by generic manufacturers in situations where it may not otherwise make sense from a business perspective. I understand that introduction of this bill has led to a robust discussion about additional and alternative ways to spur such competition. That is a good thing. I appreciate the sponsors' willingness to hear from a variety of stakeholders and work with bipartisan Committee staff to improve the bill before proceeding to markup.

I want to welcome all of our witnesses and thank you for being here. I look forward to your testimony.

## OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, and thank Dr. Woodcock for being back with us and our distinguished panelists for the hearing this morning.

Today is the first hearing of the user fee agreement reauthorization cycle. We have learned a great deal since the first prescription

drug user fee agreement authorization, and every 5 years have amended and expanded the user fee programs to build on past successes and further support timely review and approval of safe and effective medical products.

The affordability of therapies is an issue of great growing concern. Robust competition in the prescription drug market between innovative drugs and generic drugs and innovator biologics and biosimilars is crucial to providing patients with greater access to affordable therapies. Generic drugs are proven to be a safe and affordable alternative to brand name drugs.

It is estimated that generic drugs account for 89 percent of prescriptions dispensed in the U.S., but only 27 percent of the total drug cost. In 2015 alone, generic drugs saved American families $227 billion. Similar to generics, biosimilars hold great promise to make complex products available at lower cost to patients.

Due to growing concerns about the time it is taking FDA to review generic drug applications and the backlog of such applications, Congress passed the generic drug user fee amendments in 2012. Interest in participation in the program has exceeded initial predictions, and the agency has struggled to get the new program off the ground and keep up with the oversize workload and undersized resources.

GDUFA II, like subsequent reauthorizations of the prescription drug and medical device user fee programs provides an opportunity to address lessons learned from the past 4 years and improve the program so that we have a strong market of safe and effective generic drugs. Following the enactment of the Biologics Price Competition and Innovation Act, the biosimilar act, BP act, BsUFA, was established. Welcome to the FDA acronyms.

BsUFA II provides an opportunity to build on progress made and enhance the program. Stakeholders and the FDA have agreed to review timelines, meeting structures, and new programs to increase the number of first-cycle approvals which will save resources for sponsors and the agency and, more importantly, make safe and effective therapies available to patients and introduce additional competition in the market.

I look forward to hearing more about the agreements between the stakeholders and the FDA on GDUFA II and BsUFA II. It is crucial that Congress authorize these programs in a timely manner to ensure the agency has the resources and tools needed to support generic and biosimilar competition.

And I want to mention my concern about the impact of the administration's across-the-board hiring freeze with the FDA. FDA must have an adept and capable and sufficiently sized workforce to make timely scientific decisions in the interest of patients and the public health. Currently, FDA has 1,000 vacancies at the agency and the majority of which are in the Center for Drug Evaluation and Research.

We worked to help the agency attract and hire highly qualified professionals at the 21st Century Act. The hiring freeze threatens the laudable work that could have a detrimental impact on the hiring goals all ready to negotiated performance goals of the user fee agreements. I hope the administration takes this into account when implementing this deeply flawed policy.

We are also here today on H.R. 749, Lower Drug Costs through Competition Act. Over the past few months we have had productive and bipartisan conversations about the proposal and ways to achieve the shared goal of enhanced generic competition. I have concerns as the legislation is written, however, including a concept of how a priority review voucher for generic drug manufacturers will impact with existing and newly negotiated provisions of GDUFA II.

I would like to continue to work with my colleagues to improve the legislation. There is a growing bipartisan support for the government to take action and lower prescription drug costs. Rising drug costs is not a simple problem and with a simple solution. While more competition for generics and biosimilars is an important way to make medicines more affordable, it alone is not sufficient to address the problem of affordabilities.

Mr. Chairman, I would like before I yield the remainder of time to my colleague from Colorado, Congresswoman DeGette, just for the public do you have any knowledge that we are going to have a hearing next week on the markup of the Affordable Care Act?

Mr. BURGESS. It is my understanding that the markup has not been noticed and it will be noticed in a timely fashion if it occurs.

Mr. GREEN. Well, thank you for that little bit of information. I will yield my time to my colleague.

Ms. DEGETTE. Thank you. Well, just in the few seconds left I want to echo Mr. Green's concerns about this hiring freeze, particularly with the implementation of 21st Century Cures, but also with reauthorization of the UFAs, because I don't see how we can improve access if we have a hiring freeze.

The other executive order that we are deeply concerned about on both sides of the aisle is this order that you have to repeal two regulations before you can enact a new regulation, because as we are trying to implement the UFAs and also 21st Century Cures I don't see how we are going to be able to use those draconian, I think it is just draconian in this standpoint.

Mr. Chairman, I am going to have a series of questions that I am going to submit to Dr. Woodcock and our other witnesses about this, but I think this is something, a concern that we share on both sides of the aisle. And I appreciate your comity, and I yield back.

Mr. BURGESS. The chair thanks the gentlelady. Does the gentleman from Texas yield back? Apparently so. The chair then recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for an opening statement, please.

**OPENING STATEMENT OF HON. GUS M. BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA**

Mr. BILIRAKIS. Thank you. Thank you, Mr. Chairman. Again thank you for including the Lower Drug Costs Through Competition Act as part of this hearing. I am proud to join my colleague, Congressman Kurt Schrader, to responsibly use the power of the free market to bring lower prices and more drug choices to the market.

This legislation would directly address some of the problems we have seen with bad actors in the drug space such as Turing Pharmaceuticals and Valeant Pharmaceuticals. Too often we have seen

the price of lifesaving medications skyrocket due to bad actors taking advantage of monopolies in the market. We cannot allow this to continue. Our bill would incentivize drug companies to enter into these markets where no generic currently exists. My constituents in Florida and folks nationwide need relief. I hope that this committee will move this bill this month, and I yield back. Thank you, Mr. Chairman.

Mr. BARTON. Would the gentleman yield some of this time to me, Mr. Chairman?

Mr. BURGESS. The gentleman from Texas is recognized if the gentleman from Florida yields back.

Mr. BILIRAKIS. Yes, I yield back.

Mr. BARTON. I won't take any more than 3 minutes and 47 seconds. I want to thank you, Mr. Chairman, and I want to thank the ranking member, Mr. Green, for hosting this hearing today on the Biosimilar User Fee Act. Not everything in the Affordable Care Act was bad. I know that is a shock for my friends on the minority side to hear a Republican say that. But Congresswoman Anna Eshoo and myself put in a strong biosimilar section in this committee, in the Affordable Care Act markup when the Energy and Commerce Committee did that.

It was one of the few bipartisan provisions, it created a new and distinct biosimilar industry sector. Success of that regulatory provision can only be measured now by how it is implemented. We have thousands of patients, Mr. Chairman, that are facing cancer, inflammatory disease, kidney disease, and other serious disorders. We expect that they will benefit from biosimilars over the next decade. Although this is a new industry, I do believe that Congress and the administration have an important role to play in the development and success of the biosimilar marketplace.

So while this is not the focus of the hearing today, I would ask that we take a look at this CMS finalized payment methodology that they just finalized and, in my opinion, if that stands it will dramatically reduce the investment and availability of biosimilars.

So Mr. Chairman, thank you for the hearing. I look forward to hearing the witness. We are glad to have you again, you have been here before. And with that I yield back.

Mr. BURGESS. The chair thanks the gentleman. The chair recognizes the gentleman from New Jersey, Mr. Pallone, the ranking member of the full committee, 5 minutes for an opening statement, please.

**OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY**

Mr. PALLONE. Thank you, Mr. Chairman. Mr. Chairman, I must follow up on the little dialogue that you had with Ranking Member Green at the end of his statement with regard to the ACA bill. It seems like everyone knows that there is going to be a markup in full committee next Wednesday of the Affordable Care Act except for the Democrats who haven't been told anything. And I know you have long been an advocate for regular order, I just want to read this statement from the Speaker.

The Speaker on the Today Show on February 28th, he said that the majority's proposed ACA replacement legislation will be carefully considered and completed through the committee process with public engagement and transparency. We are going through the committee process step-by-step. We are having public hearings. We are having committees work on legislation. We are not hatching some bill in a back room and plopping it up on the American people's front door.

Well, I have been told, not by the Republicans, not by The Chairman, not by you, but by, you know, K Street and everyone else around here that you guys can go down to H–157 right now as we speak and go in there to the basement, the secret basement that, you know, that the Speaker says would never happen, and look at the bill that is going to be marked up next Wednesday. But I can't go down there. You know, maybe the lobbyists know where it is, they know what is in it. You know, I don't know what the media knows, but they certainly know there is a markup. Maybe the Russian ambassador is down there and he can tell us what is in the bill. Maybe they will let him in, but they won't let me in.

And I want to commend you again, Mr. Burgess, Chairman, you were on MSNBC's Chris Hayes last night and you said that you don't agree with the decision to keep the House's GOP bill secret, warning that it could backfire. You suggested Republicans owed it to the public to share their plan. It is time. Put your pencils down and turn your papers in, he told MSNBC's Chris Hayes.

So you seem to be an advocate for letting everyone see this. I mean, I would just remind you, I know you always talk about transparency with the ACA, but when the Democrats considered the ACA, the House conducted 79 committee hearings and markups over a 2-year period. The House posted the original language of the bill online for 30 days, engaging in public deliberation before the first committee held the markup.

Now from what I can see, what is going to happen is you may put out a notice Monday of a markup in full committee Wednesday, we come back Tuesday night and we won't even have 12 hours before the markup would happen. Now I don't know that that is for sure, but that is what everybody is hearing. So let me just ask you, can I go down right now myself, Mr. Green, Ms. Eshoo, can we go down to H–157 and see this bill? Would you just ask, I would like to know whether I can go down there and look at this bill.

Mr. BURGESS. Were you asking Mr. Green or myself?

Mr. PALLONE. No, I am asking you, Mr. Chairman. I mean, I like what you said on MSNBC, but can I go down and look at the bill?

Mr. BURGESS. The chair does not have that information available, but I will find out for you and relay it to you as soon as it becomes available.

Mr. PALLONE. Well, I would appreciate it because I really think that Democrats should be looking at the bill in addition to K Street, in addition to the media, and God knows what goes on with the Russian ambassador. But I want to yield the balance of my time to Mr. Schrader.

Mr. SCHRADER. Thank you. I want to thank the ranking member and thank you, Mr. Chairman, for having the hearing.

On a more bipartisan note, I think it is pretty evident American patients, states, and taxpayers, we are paying exorbitant prices for many prescription drugs, and it is really time for Congress to act. Every few months we are seeing headlines about exorbitant price hikes from unscrupulous bad actors like my good friend Gus Bilirakis talked about.

Buying the rights to produce drugs that have been on the market for decades usually where there are no competitors, seemingly overnight these prices go through the roof. In the case of Daraprim, a drug used by some transplant patients, people living with AIDS, Turing Pharmaceuticals raised the price from $13.50 per pill to $750—come on, man. Last year, Valeant, another pharmaceutical company raised the price of their drug to treat lead poisoning, been around forever, by more than 2,700 percent. That is criminal.

For both these drugs and many others, the drugs have been off patent for years and ages. There is no generic competitor on the market. Unfortunately, generic manufacturers who want to bring a competitor face this long approval process we are going to be talking about. I think GDUFA I is going to help a bunch. But our bill, lowering drug costs through competition, makes a huge difference in getting these drugs to market that much faster. It also looks at the risk mitigation strategies, potential abuse.

We have solicited feedback on our bill, look to learn more from stakeholders. This hearing hopefully provides another opportunity. It is important. I am glad we are able to come together in a bipartisan fashion to make this happen.

And I yield back, Mr. Chairman.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. We now conclude with member opening statements. The chair would like to remind members that pursuant to committee rules, all members' opening statements will be made part of the record.

For what purpose does the gentleman from Oregon seek recognition?

## OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Just to make a brief opening statement, Mr. Chairman. And I want to commend my colleague from Oregon and my colleague from Florida for bringing this legislative concept forward. It is one we have talked about. I think it makes a lot of sense. It is a piece of the puzzle, it is not the whole puzzle. It doesn't solve all the problems, but that is how we are going to look at this, a piece at a time trying to get it right.

And so I commend Mr. Schrader. I commend Mr. Bilirakis and others, and I want to thank our witnesses for their participation today. And we look forward to bipartisan legislation when it comes to this and other issues before the committee. With that I yield back.

[The prepared statement of Mr. Walden follows:]

### PREPARED STATEMENT OF HON. GREG WALDEN

Thank you Chairman Burgess.

I can say without a doubt that this critically important FDA user fee reauthorization process is in good hands with you at the helm. I remember you leading the charge during the last reauthorization cycle in 2012 to push for a number of key process improvements at the agency that have directly benefited patients. This subcommittee hearing, and those that will follow starting later this month, are great opportunities to learn how we can build upon those efforts, as well as on the many game-changing provisions in the 21st Century Cures Act, which I am committed to ensuring is fully funded and implemented. A point I made clear to the President last month.

And, Chairman Burgess, you are exactly right that we are both committed to a timely user fee reauthorization and it is my goal, in working with the Senate, to move legislation through Congress and on to the President's desk well in advance of the August recess. Committee staff has already hit the ground running and has been meeting frequently on a bipartisan basis with FDA and the industry negotiators to review the agreements and iron out technical issues with the legislative language.

Reauthorizing improved generic and biosimilar user fee programs will lead to timelier approvals and lower drug costs. It's that simple.

I also want to take a minute to applaud my friend from Oregon, Rep. Schrader, and Rep. Bilirakis, for working together on pursuing additional ways to promote more generic competition, particularly in therapeutic areas where it is sorely lacking.

Thank you to Dr. Woodcock and her team at FDA, as well to the industry negotiators here today. I look forward to working with all of you in my capacity as Chairman going forward.

I yield back the balance of my time.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. And again we want to thank all of our witnesses for being here today, for taking time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement followed by questions from members.

We have two panels of witnesses today, and we will begin with Dr. Janet Woodcock, the director, Center for Drug Evaluation and Research at the Food and Drug Administration. We appreciate you being here this morning, Dr. Woodcock. You are recognized for 5 minutes for an opening statement, please.

## STATEMENT OF JANET WOODCOCK, M.D., DIRECTOR, CENTER FOR DRUG EVALUATION AND RESEARCH, FOOD AND DRUG ADMINISTRATION

Dr. WOODCOCK. Thank you. We are here today to discuss the proposed reauthorization of two user fee programs known by the acronyms of GDUFA and BsUFA that support review of generic drugs and biosimilar drugs, respectively. FDA approval of generic or biosimilar versions of brand drugs after patent and exclusivity protections have expired, introduces competition into the marketplace and results in more affordable medicines.

Indeed, generic drugs are estimated to have saved the American public $1.5 trillion over the last 10 years. Almost 90 percent now of all prescription drugs dispensed in the U.S. are generics. Before GDUFA I was enacted, Congress, the industry, and FDA all recognized that the program was a victim of its own success and it was not able to keep up with the flood of applications that were coming in.

Congress authorized GDUFA I, and I am happy to report it has been a success. FDA has met all the program goals of GDUFA I. In addition, virtually all of the piled up applications have been reviewed and either approved, they have been sent to the manufac-

turer for the deficiencies, or they are in a new review cycle. So they are all in process of the review process.

FDA approved or tentatively approved 835 generic drugs in fiscal year 2016, which is a new record, and over the 4 years of this program so far we have approved 56 new generics, first generic drugs. Similarly, the biosimilar user fee program is on track to provide affordable alternatives to biologicals. So far, four biosimilars have been approved and we are working on 64 development programs with developers that would provide competition for 23 biologics. We have also issued six final and four draft guidances.

But these user fee programs are version 1.0. We and industry have learned a lot in the course of operating these over the last 4-plus years. So over the past year, we worked hard with industry to envision ways to improve the program that meets the industry's need for timeliness, transparency, predictability, but also meets the public's need for a steady flow of high quality affordable medicines.

We think the proposals for GDUFA and BsUFA II meet these twin objectives from both the public good and working well for industry and the agency. Additionally, across multiple drug user fee programs that are up for reauthorization, we have added new financial management provisions and modified fee structures in a way that will simplify and improve the infrastructure of all these user fee programs, so that is a part of these two new programs.

As in your work with 21st Century Cures, which we were happy to work with you on, these user fee programs are intended to improve U.S. citizens' access to safe and effective medicines, and it is really important that they be reauthorized because they are providing that function now.

I will be happy to answer any questions.

[The prepared statement of Janet Woodcock, M.D. follows:]

# Generic Drug User Fee Act Reauthorization (GDUFA II)

# Biosimilar User Fee Act Reauthorization (BsUFA II)

**Testimony of Janet Woodcock, M.D.**
Director, Center for Drug Evaluation and Research
U.S. Food and Drug Administration

**Before the**
**United States House of Representatives**
Committee on Energy and Commerce
Subcommittee on Health

**March 2, 2017**

U.S. Department of Health and Human Services
U.S. Food and Drug Administration
Center for Drug Evaluation and Research
www.fda.gov/drugs





## Introduction

Mr. Chairman and Members of the Subcommittee, I am Dr. Janet Woodcock, Director of the Center for Drug Evaluation and Research (CDER) at the Food and Drug Administration (FDA or the Agency), which is part of the Department of Health and Human Services (HHS). Thank you for the opportunity to be here today to discuss the first reauthorization of the Generic Drug User Fee Amendments (GDUFA), also referred to as GDUFA II, as well as the first reauthorization of the Biosimilar User Fee Act (BsUFA), also referred to as BsUFA II. Under these user fee programs, industry agrees to pay fees to help fund a portion of FDA's drug review activities while FDA agrees to overall performance goals, such as reviewing a certain percentage of applications within a particular time frame. Under these user fee programs FDA has dramatically reduced the review time for new products, without compromising the Agency's high standards for demonstration of safety, efficacy, and quality of new drug products prior to approval.

## Reauthorization of GDUFA

The remarkable success of the GDUFA program demonstrates how FDA, industry and other stakeholders can work together to achieve tremendous results. GDUFA has expanded access to affordable generic medicines. About 25 percent of all generic drugs that FDA has ever approved were approved in the past four years. At the same time, GDUFA helps assure the quality of generic drugs. Patient confidence that generic drugs will work the same as brand products, and can be freely substituted, is the foundation for trillions of dollars in savings that generics produce for the healthcare system.

**Historically, the generic drug program has been a great success.**

The generic drug industry has grown from modest beginnings into a major force in healthcare. According to the QuintilesIMS Institute, generic drugs now account for 89 percent of prescriptions dispensed in the United States, and saved the U.S. healthcare system $1.46 trillion from 2005 to 2015.

**This success brought new challenges.**

Over the last several decades, the generic industry, the number of generic drug applications, and the number of foreign facilities making generic drugs grew substantially. As a result, FDA's generic drug program became increasingly under-resourced. Its staffing did not keep pace with the growth of the industry.

**Solution: GDUFA**

After much negotiation, FDA and the generic drug industry, in consultation with other stakeholders, developed a proposal for a generic drug user fee program and submitted it to Congress. Congress enacted it (GDUFA I) as part of the Food and Drug Administration Safety and Innovation Act of 2012 (FDASIA).

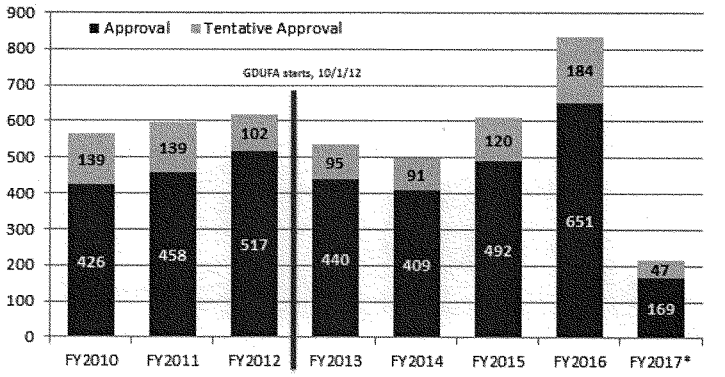
Under GDUFA I, industry agreed to pay approximately $300 million in fees each year of the five year program. In exchange, FDA committed to performance goals, including a commitment to complete reviews in a predictable time frame.

## *GDUFA Achievements*

Met or Exceeded All Submission Review Goals to Date. FDA met or exceeded all GDUFA review goals to date, including goals for original Abbreviated New Drug Applications (ANDAs), ANDA amendments, Prior Approval Supplements (PAS), and controlled correspondence.

Record Increase in Approvals. In FY 2016, FDA approved or tentatively approved 835 ANDAs. This was the most approvals ever in one year. Our previous high was 619.

**Figure 1. FY2016 – A Record Year**
**Approvals and Tentative Approvals**




*As of 1/1/17. Numbers are based on preliminary data that will be reviewed and validated for official reporting purposes.

Expanded Consumer Access to Quality, Affordable Generic Medicines. As noted previously, approximately 25 percent of all currently approved generic drugs were approved over the past four years.

Prioritization and Approval of "First Generics." FDA expedites the review of potential "first generic" ANDAs because they can open the market to generic competition for the first time. Most "first generic" ANDAs cannot lawfully be filed until a specific date, either four or five years after the innovator drug was approved. On this date, FDA often receives a bolus of ANDAs, from many different applicants. Beginning October 2014, in accordance with GDUFA I, these ANDAs received goal dates. We worked hard to review ANDAs for first generics even faster, expediting their review like an express line at the supermarket. For example, last year we had timely approvals of nine generic versions of Crestor, a cholesterol drug with approximately $5 billion in annual sales. Significant first generic approvals for 2016, and the indications (abbreviated) for which these products were approved, are listed in the text box below.

| Significant First Generic Approvals for Calendar Year (CY) 2016 | |
|---|---|
| **Brand (Generic Name)** | **Indication** |
| Namenda (Memantine Hydrochloride) Extended Release | Alzheimer's Disease |
| Nasonex (Mometasone Furoate) Nasal Spray | Allergies |
| Tamiflu (Oseltamivir Phosphate) | Influenza A and B |
| Crestor (Rosuvastatin Calcium) | High cholesterol |
| Ammonul (Sodium Phenylacetate and Sodium Benzoate) | Acute hyperammonemia and associated encephalopathy<br>• Approved for Orphan Indication<br>• Acute hyperammonemia is life-threatening emergency that can rapidly result in brain damage or death |
| Benicar (Olmesartan Medoxomil) | High blood pressure |
| Seroquel XR (Quetiapine Fumarate) | Schizophrenia; Bipolar Disorder |
| Cellcept (Mycophenolate Mofetil Hydrochloride) Injectable | Prevent organ rejection for kidney, heart, or liver transplants |
| Emend (Fosaprepitant Dimeglumine) | Chemotherapy-associated nausea and vomiting |
| Sprycel (Dasatinib) | Cancer (Chronic Myeloid Leukemia) |
| Treanda (Bendamustine Hydrochloride) | Cancer (Chronic Lymphocytic Leukemia) |
| Sustiva (Efavirenz) | HIV-1 infection |
| Kaletra (Lopinavir and Ritonavir) | HIV-1 infection |
| Tikosyn (Dofetalide) | Atrial fibrillation/flutter |
| Banzel (Rufinamide) | Seizures |

Increase in First Cycle Approvals. Prior to GDUFA, ANDAs were approved in one review cycle less than one percent of the time. Now, approximately nine percent of ANDAs are approved in the first review cycle.

Expanded Communications. To facilitate generic drug approval, in CY 2016 the Agency sent product developers approximately 1,800 communications and ANDA applicants approximately 6,600 communications. The Agency also issued 158 product-specific guidances, identifying methodologies for developing drugs and generating evidence needed to support generic approval. These guidances help companies develop ANDAs that will meet FDA's regulatory expectations. Over 1,500 product-specific guidances are currently available as resources for prospective applicants.

Risk-Based Inspection Parity. Before 2012, the law required us to inspect domestic facilities at a two-year interval, but was silent on frequency for foreign facilities, regardless of their relative risk. Since 2012, FDASIA directed us to target inspections globally on the basis of risk. Many ANDAs rely on third-party facilities to manufacture active pharmaceutical ingredients or perform other roles in product development, and many of these facilities are located outside of the United States. Thanks to GDUFA, we have achieved the goal of risk-based inspection parity for foreign and domestic facilities.

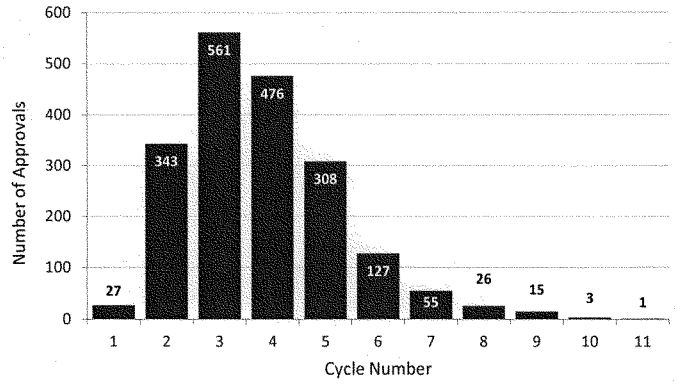
**How did FDA achieve these results?**

Deep, foundational restructuring. We achieved these results by building a modern generic drug program to comply with our commitments in GDUFA I. This involved major reorganizations. We reorganized the Office of Generic Drugs and elevated it to "Super-Office" status, on par with the Office of New Drugs. We established a new Office of Pharmaceutical Quality to integrate the quality components of ANDA review. FDA's Office of Regulatory Affairs also made significant inspection program enhancements. In addition, we reengineered our business processes, developed an integrated informatics platform to support the review process, and hired and trained over 1,000 new employees.

## *Current Challenges*

We do have some ongoing challenges. The first challenge relates to submission completeness. Historically, it has taken on average about four review cycles to approve an ANDA as a result of deficiencies by generic drug sponsors in submitting complete applications.

**Figure 2. Review Cycles for ANDAs**
**2009 through July 2014**



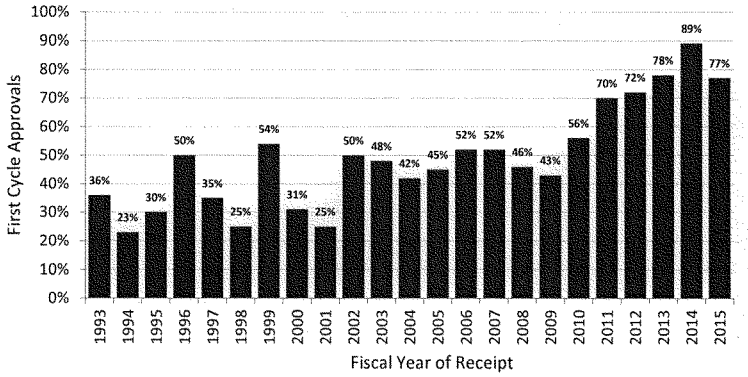

This has resulted in the submission of numerous amendments to applications by the companies to correct deficiencies in the original ANDAs and comprises a huge amount of re-work for FDA and industry alike. Currently, about 1,800 applications are back with industry awaiting resubmission to correct deficiencies in the original application. More work by both FDA and industry will be necessary to have the filings be "right the first time."

Improvement may take some time. In the first few years of the Prescription Drug User Fee Act (PDUFA) program, the first cycle approval rate for new drugs was as low as 23%. Now it is about 80% on average. Achieving this was the result of many years of cooperative work by the Agency and industry in establishing standards and meeting these expectations.

**Figure 3. First Cycle Approval Rate Under PDUFA**

**CDER NME NDAs/BLAs†**

**First Action Approval Rate**



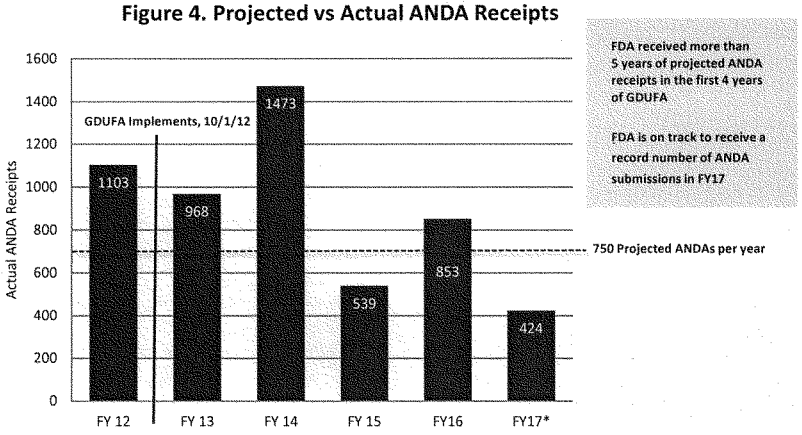

Data as of 12/9/2016

† Multiple applications pertaining to a single new molecular/biologic entity (e.g., single ingredient and combinations) are only counted once. Therefore, the numbers represented here for filings are not indicative of workload in the PDUFA V Program.

† Original BLAs that do not contain a new active ingredient are excluded. Percentages exclude pending applications from the denominator.

The second challenge relates to the volume of applications. We received many more applications than expected. As the GDUFA I Commitment Letter stated, GDUFA I review goals and planning were based on the assumption that FDA would receive approximately 750 ANDAs per year. We budgeted and planned with this projection in mind. However, in FYs 2012, 2013 and 2014, we received over 1,000, nearly 1,000 and nearly 1,500 applications, respectively. As discussed below, GDUFA II would have a program size commensurate with the Agency's overall ANDA workload.

**Figure 4. Projected vs Actual ANDA Receipts**




* As of 12/31/16. Numbers are based on preliminary data that will be reviewed and validated for official reporting purposes.

Third, several factors can delay timely consumer access to less expensive generic medicines. These factors include:

- inappropriate use of statutory requirements regarding single-shared system Risk Evaluation and Mitigation Strategies (REMS) to delay generics entry to the market;
- delaying or denying generic companies' access to reference listed drug products, thereby preventing the companies from conducting studies required for approval; and
- misuse of FDA's citizen petition process as a means to block generic approvals.

## *Reauthorization*

Faster review of priority ANDAs. GDUFA II would establish faster review of priority submissions. Priority review would be available for submissions that FDA considers to be public health priorities pursuant to CDER's Manual of Policies and Procedures (MAPP) 5240.3 Rev.2, *Prioritization of the Review of Original ANDAs, Amendments and Supplements,* as revised (the CDER Prioritization MAPP). In the final year of GDUFA I, all ANDAs receive a review goal of 10 months. In GDUFA II, standard ANDAs would continue to be reviewed within 10 months of submission. But priority ANDAs would be reviewed within eight months of submission. To help ensure the more aggressive eight month timeline can be met, for each priority review, the applicant would have to submit a pre-submission facility correspondence (PFC) listing all of the facilities that will require FDA inspection at least two months prior to the date of ANDA submission.

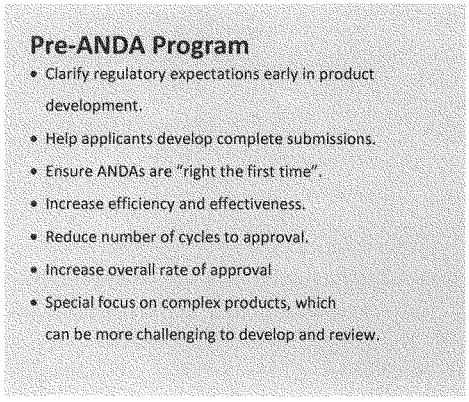
**GDUFA II – Faster Review of Priority ANDAs**

- GDUFA I: 10 month review of all ANDAs.
- GDUFA II Proposal: 8 month review of Priority ANDAs.
- Front end: FDA identifies and communicates deficiencies in "real time".
- Back end: Applicants can correct deficiencies.
- Increase odds of approval in current review cycle.
- Reduce number of cycles to approval.
- Increase overall rate of approval.
- Concept drawn from PDUFA.

FDA and the generic drug industry agreed to an eight month priority review goal for two main reasons: First, it is the shortest time feasible given the global nature of generic drug manufacturing. In most cases, before the ANDA can be approved, FDA needs to inspect one or more manufacturing facilities to confirm that the drug will meet quality standards. Many ANDA applicants rely on multiple overseas manufacturing facilities, and conducting inspections of facilities in foreign countries requires additional time for FDA inspectors to obtain State Department approval and country-specific visas, and to meet other travel-related requirements. By providing FDA with information about the manufacturing facilities in advance of the ANDA submission, the PFC would give the Agency critical lead time to determine whether facility inspections will be needed, and when they are, to initiate travel planning.

Second, eight months is enough time for FDA to communicate–and applicants to correct–application deficiencies, so a priority ANDA can be approved in the current review cycle, not a later review cycle. A goal date set at fewer than eight months would wind down work just when it is gaining momentum. Applicants would not have time to make corrections and thus get their ANDAs approved. To resolve outstanding issues, an additional cycle of review would be necessary. Approval would be delayed for at least six to 10 more months, depending on how quickly the applicant could develop an amendment and the GDUFA II review goal for the specific type of amendment submitted.

Pre-ANDA Program Enhancements.
To reduce the number of cycles to approval, particularly for complex products, GDUFA II would establish a pre-ANDA program. It would clarify regulatory expectations for prospective applicants early in product development and help applicants develop more complete submissions, thus promoting a more efficient and effective review process.

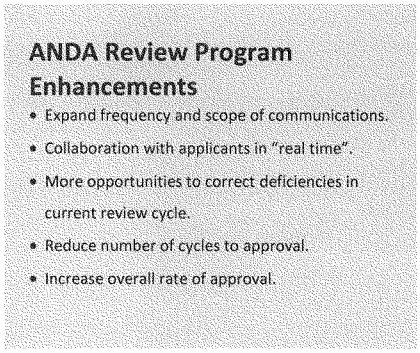



The GDUFA II pre-ANDA program would establish three types of meetings for complex products. In a product development meeting, FDA would provide targeted advice concerning an ongoing ANDA development program. Pre-submission meetings would give applicants an opportunity to discuss and explain the content and format of an ANDA before it is submitted. Mid-review-cycle meetings would occur post-submission, after the last key review discipline has communicated deficiencies, and would enable applicants to discuss current concerns and next steps. FDA intends to issue a guidance concerning the pre-ANDA program, setting forth meeting policies and procedures. In addition, the Agency intends to establish metric goals for product development and pre-submission meetings.

For products that are not complex, GDUFA II would direct the Agency to establish metric goals for FDA to issue product-specific guidance. Product-specific guidance identifies the

methodology for developing generic drugs and generating evidence needed to support generic approval. They help companies develop ANDAs that will meet FDA's regulatory expectations. In addition, the pre-ANDA program would enhance controlled correspondence, regulatory science, the Inactive Ingredient Database, and Safety Determination Letters.

ANDA Review Program Enhancements. GDUFA II would further refine and modernize the ANDA review process from start to finish.




The GDUFA II ANDA review program would start with submission of an ANDA. When an ANDA is submitted, FDA first determines whether an ANDA is sufficiently complete to permit a substantive review. If it is sufficiently complete, then FDA "receives" it within the meaning of the statute. FDA would aspire to make these receipt determinations within consistent deadlines. The Agency also would increase receipt-related communications in an attempt to fix applications and resolve certain receipt disputes within consistent timelines.

When the ANDA has been received and is under review, pursuant to GDUFA II, FDA would communicate review deficiencies beginning at about the mid-point of the review. Then, communications would continue on a rolling basis. In GDUFA I, many deficiencies were communicated at the very end of the review, in the form of a Complete Response Letter, too late for the applicant to fix them. This produced additional cycles of review, and delayed approval. By contrast, GDUFA II would use "real time" communications to give applicants more opportunities to correct deficiencies in the current review cycle.

To support product launches and business planning that can improve access to generics, Regulatory Project Managers (RPMs) would provide review status updates and certain other

types of notifications. The Agency would also establish new technical procedures to facilitate approval of tentatively approved ANDAs on the earliest lawful approval date.

When deficiencies in an ANDA prevent FDA from approving it, FDA issues a Complete Response Letter (CRL) itemizing deficiencies that must be corrected for the ANDA to be approved. GDUFA II would establish post-CRL teleconferences to allow applicants to seek clarification concerning deficiencies identified in CRLs. This would help applicants meet FDA's expectations when an ANDA is re-submitted for additional review. There would be metric goals for such teleconferences, and for formal dispute resolutions.

Finally, in GDUFA I, different cohorts and tiers of submissions received very different goals. The scheme was challenging for FDA to operationalize and administer. In addition, there was a significant gap between the negotiated commitments and stakeholder expectations. We appreciate that this has been an understandable area of concern for all of us. In GDUFA II, all ANDAs and ANDA amendments would fall within a single, consolidated review goals scheme. This would simplify and streamline GDUFA operations, and better align commitments with expectations.

Drug Master File (DMF) Review Program Enhancements. DMFs are submissions that provide FDA with confidential information about facilities, processes, or articles used to manufacture, process, package, or store drugs. They support approval of ANDAs and are often submitted by API manufacturers that sell to ANDA sponsors. The commitment letter that accompanies GDUFA II contains five significant DMF review program enhancements.

Facility Assessment Enhancements. As previously mentioned, FDASIA eliminated longstanding minimum inspection frequency requirements and, instead, directed FDA to inspect drug facilities globally on the basis of risk. The transition to this new paradigm has been commercially disruptive for industry, which over time had developed expectations and business processes based on the old model. To mitigate export-related challenges identified by U.S.-based active pharmaceutical ingredient (API) manufacturers, GDUFA II would require FDA to issue guidance and conduct outreach to foreign regulators on the risk-based selection model and take steps to support exports. To mitigate ANDA sponsor concerns, FDA would enhance the speed and

transparency of communications concerning facility assessment, and generally update and seek feedback from industry. In addition, to enhance transparency concerning GDUFA facilities and sites, FDA would update its existing, publicly-available facility compliance status database.

Accountability and Reporting Enhancements. In GDUFA II, enhanced infrastructure and analytics would increase transparency and accountability and strengthen program management and resource use. FDA would develop internal capacity to enable improved productivity and performance through regular assessment of progress towards GDUFA II goals and transparent, efficient administration, allocation and reporting of user fee resources. In addition, an independent third party would evaluate the program.

FDA would expand GDUFA program reporting on a monthly, quarterly and annual basis. Robust performance reporting would enable Congress, industry and other stakeholders to gauge the generic drug program's performance.

Program Size Commensurate with Overall ANDA Workload. ANDAs are the primary workload driver of the generic drug program. In GDUFA I, the number of submissions received substantially exceeded projections. In order to maintain productivity and implement proposed GDUFA II improvements, FDA and the generic drug industry agreed that user fees should total $493.6 million annually, adjusted for inflation.

Modification of User Fee Structure. For program stability, user fee collections must be predictable. Application volume can fluctuate from year to year. But there is a relatively stable universe of generic drug facilities and ANDA sponsors. To maintain a predictable fee base and better align responsibility with program costs and fee-paying ability, FDA and industry propose to shift the burden more towards annual program fees. Firms that sponsor one or more approved ANDAs would pay an annual fee. In addition, Finished Dosage Form (FDF) and API facilities would continue to pay annual fees as they did in GDUFA I.

In GDUFA I, ANDA sponsors making changes to an already approved ANDA through a Prior Approval Supplement (PAS) were required to pay a PAS application fee. The volume of PASs is unpredictable. Collecting the fees was resource intensive. The new ANDA program fee is meant

to be an investment in the program, and includes the cost of reviewing PAS submissions. For these reasons, FDA and industry propose to eliminate the PAS fee.

Small Business Considerations. GDUFA II takes small business considerations into account. First, no facility or ANDA sponsor would be charged an annual fee until an ANDA in which it is listed is approved. This eliminates a situation that occurred in GDUFA I, where a company could be charged an annual fee, sometimes for several years in a row, even though no ANDA linked to the facility had been approved yet. Second, the annual program fee would have three tiers–small, medium and large–based on number of approved ANDAs owned by the firm and its affiliates. Third, Contract Manufacturing Organizations (CMOs are hired by ANDA sponsors to manufacture their generic drugs) would pay one-third the annual facility fee paid by ANDA holders.

In summary, FDA and the regulated industry, in consultation with other stakeholders, spent nearly a year developing the proposed GDUFA II agreement. It contains numerous, major reforms to address the main challenge facing the generic drug review program–namely, multiple review cycles. It is very inefficient for FDA and applicants alike to cycle through an ANDA over and over again. GDUFA II's pre-ANDA program, ANDA review program enhancements, and priority review program will increase the odds of first cycle approval, reduce the number of cycles to approval, and expand consumer access to quality, less expensive generic medicines. While we have made significant progress in our generic drug review, GDUFA II will support the agency in improving consumers' timely access to generic medicines.

## Reauthorization of BsUFA

FDA is supportive of and fully engaged with the development and approval of biosimilar and interchangeable products. Many of our most important drugs are biological products. Biological products are used to treat patients who have serious and life-threatening medical conditions including rheumatoid arthritis, diabetes, and cancer. It is important for the public health of the U.S. population to have access to safe, effective, and affordable biological products. Biosimilars can provide more treatment options for patients, and possibly lower treatment costs, enabling greater access for more patients.

To earn and sustain both physicians' and patients' confidence in biosimilar and interchangeable products, FDA is applying a scientifically rigorous review process and approval standard. Healthcare providers and patients have consistently emphasized that FDA's approval of biosimilars should provide assurance that biosimilars will have the same clinical performance as the originator, or reference product. FDA is committed to providing this assurance, and recognizes its importance to the uptake and acceptance of these products, and the future success of the biosimilars program.

## *Biologics Price Competition and Innovation Act (BPCI Act) and Biosimilar User Fee Act (BsUFA): Important Additions to FDA Statutory Authority*

### BPCI Act

As you know, the Biologics Price Competition and Innovation (BPCI) Act established a new abbreviated approval pathway for biological products shown to be "biosimilar to" or "interchangeable with" an FDA-licensed biological product. With this abbreviated approval pathway, an applicant can get a biosimilar approved by demonstrating, among other things, that it is highly similar to a reference biological product already licensed by FDA. Biological products are made from living organisms and usually consist of large, complex molecules that cannot be easily copied, in contrast to "small molecule" drugs that generally are produced through chemical processes and can be replicated as "generic" drugs. Unlike generic drugs, biosimilars must be highly similar to, not the same as, the reference product to which they are compared. While biosimilars may have certain allowable differences from the reference product, the

applicant must demonstrate that there are no clinically meaningful differences between the biosimilar and its reference product in terms of safety, purity and potency.

The abbreviated approval pathway permits a biosimilar application to rely, in part, on FDA's previous determination that the reference product is safe and effective, saving the applicant time and resources and thereby encouraging price competition and lowering healthcare costs. The ongoing and future impact of this relatively new law is significant. FDA's biosimilars program has sparked the development of a new segment of the biotechnology industry in the United States. The growth of this new market segment should expand opportunities for technical innovation, job growth, and patient access to treatment.

**BsUFA I**

The Biosimilar User Fee Act (BsUFA) was enacted as part of the FDA Safety and Innovation Act (FDASIA) (Public Law No. 112-144, enacted on July 9, 2012). The first Biosimilar User Fee Agreement (BsUFA I) between the Agency and industry allowed FDA to begin development of the infrastructure needed to support this new program and devote additional resources to support the abbreviated development process leading to the approval of safe and effective biosimilar products for patients.

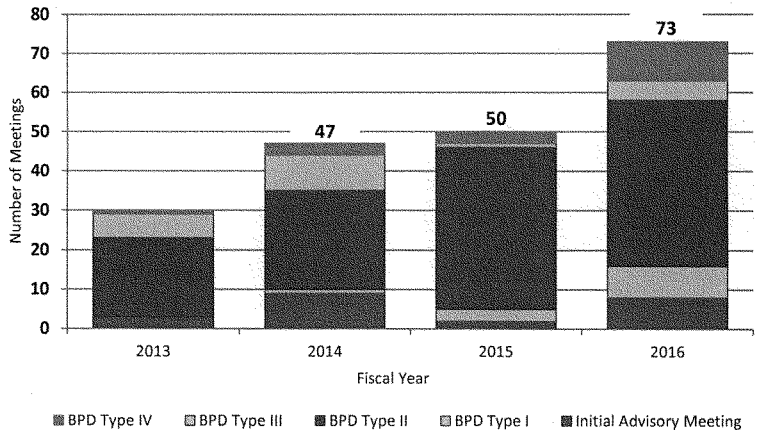
One of the first steps in the development and review process for a biosimilar is for an applicant to join FDA's Biosimilar Product Development (BPD) Program. The BPD Program was created as a part of BsUFA I to provide a mechanism and structure for applicants to engage with FDA during the development of a biosimilar. As of February 2017, 64 programs were enrolled in the BPD Program and CDER has received meeting requests to discuss the development of biosimilars for 23 different reference products.

In engaging with sponsors regarding biosimilar development, CDER holds development-phase meetings and provides written advice for ongoing development programs. These meetings include a Biosimilar Initial Advisory meeting where there is an initial discussion on whether licensure would be feasible for a particular product; and BPD meeting Types 1-4 where applicants can receive advice at different stages of product development. The meeting that is in highest demand and often requires significant review effort on behalf of FDA is the BPD Type 2

meeting where FDA conducts a substantive review of summary data and an applicant receives advice on specific issues. For additional details on the BsUFA BPD meeting types, please see Appendix A.

As shown in Figure 5 on the next page, the total number of meetings scheduled has increased each year since the beginning of BsUFA I. Additionally, in order to provide ongoing support for BPD programs, FDA has provided written advice to sponsors in instances where meeting requests were denied or cancelled due to incomplete or premature requests.

**Figure 5. Number of BsUFA Program Meetings Scheduled**
**FY 2013 - FY 2016**




The BPD meetings have provided valuable advice to biosimilar sponsors in the development of their products and associated biosimilar marketing applications. Since program inception and as of February 2017, nine companies have publicly announced submission of 13 applications for proposed biosimilar products to FDA.

FDA approved the first biosimilar in the United States, Zarxio (filgrastim-sndz), a biosimilar to Neupogen, on March 6, 2015. In 2016, FDA approved three additional biosimilars: Inflectra (infliximab-dyyb), a biosimilar to Remicade; Erelzi (etanercept-szzs), a biosimilar to Enbrel; and Amjevita (adalimumab-atto), a biosimilar to Humira.

## *Challenges*

While we have made significant progress in creating and implementing this fairly new program, there is more work to do and, as with any new initiative, there are challenges that we need to address. These challenges in BSUFA I provide context for the discussions we had with industry during the BSUFA II negotiations. The ability to hire the right staff is critical to ensure the timely review of new biosimilars. While it's true that FDA has been somewhat limited in its capacity to recruit and retain the critical scientific, technical, and professional talent needed to address the complex and often novel scientific and legal issues involved in biosimilar review, we are committed to making meaningful and measureable progress.

The lack of additional staffing to handle the increased workload for biosimilar review also has impacted review performance. For example, in FY 2015, FDA was able to schedule only 50 percent of Initial Advisory meetings within the 90 day meeting goal, only 67 percent of Type 1 meetings within the 30 day meeting goal, only 49 percent of Type 2 meetings within the 75 day meeting goal, and zero Type 4 meetings within the 60 day meeting goal. FDA's performance during FY 2016 was an improvement from FY 2015; however, FDA still faced challenges and was unable to meet some of the applicable performance goals. Despite the BsUFA I performance challenges, industry indicated that in BsUFA II, they would like to see more meetings and faster turnaround of Agency advice.

## *BsUFA II*

FDASIA directed FDA to develop recommendations for BsUFA II for fiscal years 2018 through 2022. To develop these recommendations, FDA consulted with industry and public stakeholders, including scientific and academic experts, health care professionals, and patient and consumer advocates, as directed by Congress. In addition to meetings with industry

organizations, FDA held two public meetings on December 18, 2015 and October 20, 2016 to obtain input from public stakeholders.

As discussed below, BsUFA II incorporates lessons learned from implementation of BsUFA I and provides a roadmap to successfully overcome some of the unexpected challenges encountered with BsUFA I.

Proposed Fees. At the time BsUFA I was authorized, the size and costs of the program were uncertain. As such, it was agreed that user fees for BsUFA I should be based off the fees established under the PDUFA program. As part of the recommendations for BsUFA II, FDA and industry agreed to establish an independent fee structure based on BsUFA program costs to generate a total of $45 million in revenue for FY 2018. FDA and industry representatives also propose that FDA can adjust this amount to reflect updated workload and cost estimates for FY 2018 when FDA publishes the Federal Register (FR) notice establishing fee revenue and fees for FY 2018. The adjustment cannot increase the target revenue more than $9 million, and FDA must describe the methodology used to calculate the adjustment in the FR.

FDA's recommendations for the BsUFA II user fee structure include additional changes to enhance the predictability of BsUFA funding levels and sponsor invoices, minimize inefficiency by simplifying the administration of the program, and improve FDA's ability to manage program resources and engage in effective long-term planning. These changes include the removal of the supplement fee and establishment fee, while retaining the initial, annual, and reactivation biosimilar biological product development (BPD) fees. Under the recommendations, the product fee is renamed the BsUFA Program fee and includes a new provision that sponsors shall not be assessed more than five BsUFA Program fees for a fiscal year per application. These changes are consistent with changes proposed for the fee structure under PDUFA VI.

Under BsUFA II, FDA also would establish a capacity planning adjustment as well as an operating reserve adjustment. The capacity planning adjustment, once operational (expected in FY 2021), would establish a mechanism to adjust the annual fee revenue target based on analytically-demonstrated sustained changes in BsUFA workload. The operating reserve adjustment would provide the ability to further adjust up or down the annual fee revenue to

ensure the program is adequately resourced to sustain operations, while also preventing the accrual of unnecessarily large carryover balances. Under BsUFA II, the $20 million (adjusted for inflation) spending trigger would be considered to be met in any fiscal year if the costs funded by budget authority are not more than 15 percent below the inflation adjusted amount for that year. This flexibility, similar to the spending trigger provisions in PDUFA and GDUFA, will enhance FDA's level of certainty that it can allocate and spend the required amount of non-user fee funds for a given fiscal year and thereby spend user fee funds in that fiscal year.

Proposed Performance Goals. The BsUFA II commitment letter establishes an application review model similar to "the Program" established under PDUFA V for new molecular entity new drug applications and original biological licensing applications. This new model is intended to promote the efficiency and effectiveness of the first cycle review process and minimize the number of review cycles necessary for approval. The parameters of the Program will include the following: 1) pre-submission meeting, 2) original application submission, 3) Day 74 Letter, 4) review performance goals (10 month user fee clock starts at 60-day filing date), 5) mid-cycle communication, 6) late-cycle and advisory committee meetings, 7) inspections, and 8) assessment of the Program.

The additional two-month review clock time (10 month plus 60 days, noted above) is intended to provide FDA more time to complete additional late cycle activities added as part of the new review model (e.g., late-cycle meeting) and address other late cycle review work, such as application deficiencies, Advisory Committee advice, and inspection issues to improve the efficiency of the first review cycle.

Under the BsUFA II commitment letter, Biosimilar Initial Advisory meetings will occur within 75 calendar days, instead of 90 days agreed to in BsUFA I, from receipt of the meeting request and meeting package. This type of meeting will be limited to a general discussion on whether a proposed product could be developed as a biosimilar and to provide high-level overarching advice on the expected content of the development program. To provide necessary time for FDA discussions and to develop comprehensive responses, BPD Type 2 Meetings will occur within 90 calendar days, instead of 75 days as in BsUFA I, from receipt of the meeting request and meeting package. There will be phased-in performance goals for meeting these deadlines of 80 percent in fiscal years 2018 and 2019 and 90 percent in fiscal years 2020 through 2022.

In addition, the Agency will send preliminary responses to the sponsor's questions contained in the background package no later than five calendar days before the face-to-face, videoconference or teleconference meeting date for BPD Type 2 and Type 3 meetings.

Proposed Guidance Development. While the BPCI Act states that there is no requirement for FDA to issue guidance before reviewing or taking an action on a biosimilar application, industry has indicated to FDA that guidances are an important product development tool. As part of its work to implement the BPCI Act, FDA has finalized six guidances and issued four draft guidances. The six guidances that are final are:

1. *Scientific Considerations in Demonstrating Biosimilarity to a Reference Product* (finalized on April 28, 2015)
2. *Quality Considerations in Demonstrating Biosimilarity of a Therapeutic Protein Product to a Reference Product* (finalized on April 28, 2015)
3. *Biosimilars: Questions and Answers Regarding Implementation of the Biologics Price Competition and Innovation Act of 2009* (finalized on April 28, 2015)
4. *Formal Meetings Between the FDA and Biosimilar Biological Product Sponsors or Applicants* (finalized on November 17, 2015)
5. *Clinical Pharmacology Data to Support a Demonstration of Biosimilarity to a Reference Product* (finalized on December 28, 2016)
6. *Nonproprietary Naming of Biological Products* (finalized on January 12, 2017)

Under the BsUFA II commitment letter, FDA has committed to publishing a revised draft guidance on *Formal Meetings Between the FDA and Biosimilar Biological Product Sponsors or Applicants* no later than September 30, 2018, and updating the draft guidance on *Best Practices for Communication Between IND Sponsors and FDA During Drug Development* by December 31, 2018.

Additionally, under the BsUFA II commitment letter FDA has committed to publishing draft or final guidance describing the following:

- *Considerations in Demonstrating Interchangeability with a Reference Product* (draft on or before Dec. 31, 2017, and revised or final guidance 24 months after close of the public comment period),
- *Statistical Approaches to Evaluate Analytical Similarity* (draft on or before Dec. 31, 2017, and revised or final guidance 18 months after close of the public comment period),
- *Processes and Further Considerations Related to Post-Approval Manufacturing Changes for Biosimilar Biological Products* (draft on or before March 31, 2019, and revised or final guidance 18 months after the close of the public comment period),
- *Clinical Pharmacology Data to Support a Demonstration of Biosimilarity to a Reference Product* (draft guidance published in May 2014, revised or final guidance will be published on or before May 31, 2019)
- *Nonproprietary Naming of Biological Products* (draft guidance published in August 2015, revised or final guidance will be published on or before May 31, 2019)
- *Labeling for Biosimilar Biological Products* (draft guidance published March 2016, and revised or final guidance on or before May 31, 2019)

FDA has already published or finalized three of these guidances ahead of schedule: the draft *Considerations in Demonstrating Interchangeability with a Reference Product* and final guidance on *Clinical Pharmacology Data to Support a Demonstration of Biosimilarity to a Reference Product and Nonproprietary Naming of Biological Products.*

As with all review programs within FDA, the ability to hire and retain qualified staff is critical to ensure the availability of new safe and effective drugs and biologics. Congress included much needed new hiring authorities in the recently enacted 21st Century Cures Act. FDA looks forward to applying these new authorities to further improve our biosimilars program. Several FDA goals in the BsUFA II commitment letter support this process: FDA will strengthen staff capacity; modernize the hiring system and infrastructure; augment human resources capacity

through the use of dedicated expert contractors; establish a dedicated function for the recruitment and retention of scientific staffing; set clear goals for hiring; and conduct a comprehensive and continuous assessment of hiring and retention practices. These enhancements will allow us to meet our performance goals which in turn will help us save the applicant time and resources and ultimately encourage price competition and lower healthcare costs.

### *The Path Forward*

BsUFA I provided critically needed funding for FDA to implement the beginning of a successful biosimilars program. BsUFA II will allow FDA to continue building this program and make improvements where needed. This relatively new pathway for biosimilar and interchangeable products has the potential to offer a significant contribution to the public health of many Americans by increasing access to more affordable biologics. At FDA, we are working hard to ensure this positive impact can be realized. We are optimistic and energized about the future of biosimilars.

## CONCLUSION

Human drug user fees have revolutionized the drug review process in the United States since they were adopted 20 years ago for prescription drug products, allowing FDA to speed the application review process without compromising the Agency's high standards. User fees offer a strong example of what can be achieved when FDA, industry and other stakeholders work together on the same goal. User fees provide a critical way for leveraging appropriated dollars, ensuring that FDA has the resources needed to conduct reviews in a timely fashion. The reauthorization of GDUFA and BsUFA will allow FDA to build upon the demonstrated success of these programs.

Appendix A. BsUFA Meeting Types

The BsUFA program established five meeting types specific to biosimilar development programs:

- A Biosimilar Initial Advisory meeting is an initial assessment limited to a general discussion regarding whether licensure under section 351(k) of the Public Health Service (PHS) Act may be feasible for a particular product.
- A BPD Type 1 meeting is a meeting that is necessary for an otherwise stalled BPD program to proceed. Examples of a BPD Type 1 meeting include discussion of: a clinical hold, a special protocol assessment, an important safety issue, dispute resolution, and/or a Complete Response.
- A BPD Type 2 meeting is a meeting to discuss a specific issue (e.g., proposed study design or endpoints) or questions where FDA will provide targeted advice regarding an ongoing BPD program. This meeting type includes substantive review of summary data, but does not include review of full study reports.
- A BPD Type 3 meeting is an in-depth data review and advice meeting regarding an ongoing BPD program. This meeting type includes substantive review of full study reports, FDA advice regarding the similarity between the proposed biosimilar biological product and the reference product, and FDA advice regarding the need for additional studies, including design and analysis. This meeting has no counterpart in the Prescription Drug User Fee Act (PDUFA) program and is unique to BsUFA to support an evaluation of residual uncertainty regarding the demonstration of biosimilarity and to support the concept of stepwise evidence development.
- A BPD Type 4 meeting is a meeting to discuss the format and content of a biosimilar biological product application or supplement to be submitted under section 351(k) of the PHS Act.

Mr. BURGESS. The chair thanks Dr. Woodcock. Thank you for your testimony. We will move on to the question and answer portion of the hearing. I begin the questioning by recognizing myself for 5 minutes.

Dr. Woodcock, the FDA, Food and Drug Administration, often reviews and makes decisions on complex, novel drug applications for serious conditions within 6 months. Decisions on whether to approve such new drug applications are almost always made in the first review cycle. On the other hand, the median review times for generic drug applications have actually increased since the Generic Drug User Fee Amendments was authorized, and in 2015 reached 48 months with only nine percent of generic applications approved in the first review cycle.

So this doesn't seem like the right direction. In 5 years from now, what percentage of first-cycle approvals would you consider a success?

Dr. WOODCOCK. Well, I would consider a success to be a considerable increase over the rate we are seeing now. I think we are up about 10 percent maybe. It is hard to say with the recent submissions, but we can look at the class of 2014–2015 and see how many of those have gotten a first-cycle approval. And it is still I think under 10 percent.

So if we could get up to 20, 25 percent it would be excellent, and then keep building that over time. Because right now, if, next year if a company were to send in, if you were a company you would send in a generic drug and, say, it would be a first generic and it were a good application, it was complete, you could be on the market in 8 months.

Mr. BURGESS. I beg your pardon?

Dr. WOODCOCK. You could be on the market in 8 months.

Mr. BURGESS. 8 months. So I guess the issue is here is really how do we move the needle so that the overwhelming majority of generic applications are actually approved on the first cycle?

Dr. WOODCOCK. That is one of the goals of GDUFA II. So for complex generics we have put in and proposed a program where we would work with the companies before the application was submitted and work out a lot of the complex issues. These might be applications where there is an injector or other device used with them, or where there are very complicated molecules.

But also we plan to provide more training and interaction with industry up front in general so that they can get to a point where their applications can be approved on the first cycle.

Mr. BURGESS. Under anyone's definition that would be moving the needle. For priority submissions of noncomplex products, which according to the Food and Drug Administration itself constitute a relatively small portion of their overall workload but are especially important to public health, should the agency have a similar program to ensure quality applications are submitted at the outset, reduce the opportunity for failure?

Dr. WOODCOCK. Well, we are proposing that at least for complex drugs that there be a very intensive program to make sure that they get it right the first time.

Mr. BURGESS. Are there additional tools or authority that the Food and Drug Administration would need particularly in the

space that deals with the development of complex generics under the 505(j) pathway?

Dr. WOODCOCK. What we are proposing in GDUFA II would give us new tools. We would actually meet with the companies in advance. There would be submissions during and interactions during the review process. This is actually somewhat similar to what we do for the new drugs that you mentioned earlier.

And I will point out that the PDUFA program over the 20 years of operating has brought the first-cycle drug approval up to what, well over 80 percent of drugs that are approved on the first cycle now in the new drug side. But it wasn't that way at the beginning.

Mr. BURGESS. Dr. Woodcock, do you think the FDA needs additional authority in order to approve drugs faster on this pathway?

Dr. WOODCOCK. No. I think that we need more, the resources that we have negotiated under GDUFA II or other types of resources provided, because this is a labor-intensive activity, all these additional interactions with the industry that help them get their submission in shape the first time.

Mr. BURGESS. Well, I certainly thank you for being here today. Again, as I mentioned to you before we started, it doesn't seem possible that this is the third reauthorization that I have lived through. I really do appreciate your testimony. I appreciate putting together the list of medications that actually have been approved that may not be generally known, so I appreciate you making that as part of the packet today of information that you shared with the subcommittee.

And I will yield back my time and recognize Mr. Green for 5 minutes for questions, please.

Mr. GREEN. Thank you, Mr. Chairman. Dr. Woodcock again, welcome. The review model instituted by PDUFA is a result of lessons learned over the years and a commitment from both the FDA and industry to work towards a first-cycle approval. PDUFA now enjoys an average 80 percent first-cycle approval. One common criticism we have heard of the FDA is the need to improve the quality of applications under GDUFA so it moves more toward approving the applications in the first cycle. In fact, you note in your testimony that prior GDUFA generic applications were approved in one review cycle less than one percent of the time. That rate has increased to nine percent under GDUFA I. Following the chairman's question, follow up, can you elaborate more on how GDUFA II will improve that first-cycle approval?

Dr. WOODCOCK. Yes. Well, first of all, we are getting industry focused on the fact that the benefits of a first-cycle approval. In the past it was about a median of four cycles, and sometimes we would go up to 11 cycles, industry would go through in getting their application, and sometimes they had time because they were waiting for patents to expire or what have you.

So we are going to focus on that and then for the very complex ones we are going to put in place, we are proposing to put in place a special program where we work with the industry before they submit their application. So that is off the clock, all right. And we help them get it, meet with them and help them get it into place and we issue certain guidances early, and then we meet with them

during the program to make sure the review is on track and that they have answered all the questions.

Mr. GREEN. OK. Much attention has been given to the backlog of the generic applications. Can you help this committee understand the nature of these pending applications and what the agency has done to address them? I think you may have answered that, that you are actually working with them before filing, so I appreciate that.

On the BsUFA meeting, Dr. Woodcock, when you were here last February to testify about the implementation of BsUFA you discussed the increasing number of meeting requests that the agency was receiving from sponsors. We have heard from industry that these meetings are valuable and providing clarity about the data and the information the agency will need for approval and to address any outstanding questions FDA will have early in the process. What improvements of these meetings with sponsors will be made under BsUFA II?

Dr. WOODCOCK. Yes. Well, those meetings are very valuable. We are all feeling our way in biosimilarity. It is a new concept. It is not safety and effectiveness, it is biosimilarity that provides the entry to the market, and how to prove that is a new concept. So we had not been meeting all of our meeting goals under BsUFA I because the industry appetite for them was very large and we were not able to meet with all the industry that wanted to meet with us.

So under BsUFA II we have changed some of the timelines. We are increasing the staffing so that we will be able to meet these meeting goals and meet with industry that needs to talk with us about how to craft their biosimilar program. Much of this is analytical work, in vitro work, sometimes though there would even be a clinical trial that would be done.

Mr. GREEN. In the short time I have left, let me just ask too about some of the concerns about the, as I said in my opening statement about the number of vacancies at the FDA and also a freeze on hiring. Obviously that would hurt the process right now, and is there anything the FDA can do now with staff?

Dr. WOODCOCK. Well, as you know, our hiring problems have been persistent for the last 5 or 6 years and we have run deficits. We are working with the new administration and we hope that we will be able to address these issues, continue to address them as we have been trying to address them.

Mr. GREEN. Thank you, Mr. Chairman. I have one other question. Can you explain different considerations given under GDUFA II for small businesses, because that is one of the issues we have heard.

Dr. WOODCOCK. Yes, there is a different fee structure for a small business exemption so that that will help, and there are different levels of the program that—small business exemption, yes. It is complicated how we are doing it so we can get back to you, but we have taken the issue of small business more into account in the fee structure in GDUFA II.

Mr. GREEN. Thank you, Mr. Chairman. I yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Kentucky,

Mr. Guthrie, vice chairman of the committee, 5 minutes for your questions, please.

Mr. GUTHRIE. Thank you, Mr. Chairman. Thank you, Dr. Woodcock, for being here. We appreciate it very much. Do you know the percentages of generic drug applications that go through more than three review cycles, or how about five review cycles?

Dr. WOODCOCK. Well, it depends on when you are talking about because that is in flux right now. Historically, the median was four, so about half were less than four or less, and obviously about half were more than four, OK.

Mr. GUTHRIE. Yes.

Dr. WOODCOCK. OK, so now that is shifting a little bit. That curve is shifting to the left and we hope to see fewer and fewer total review cycles. The reason that is happening right now is because we are doing a lot of information requests and we are going back and forth with the company during the review cycle to try and get as much of this fixed as possible. And we hope that the vast majority of ones, all these ones that we have been reviewing, will be approved on the second or third cycle.

Mr. GUTHRIE. OK.

Dr. WOODCOCK. But the older ones may still need considerable fixing up before they can get approved.

Mr. GUTHRIE. You almost got to my next question, but so how many total years in like the back, when you talk about back and forth between FDA and the company, if you are in three cycles, I mean, how many years is that typically? Or maybe even 5 years.

Dr. WOODCOCK. Historically that is very difficult to say, all right. Right now the first cycle is going to be 10 months, right. And then you send it back to the company, say, if it doesn't get approved, and then it depends on when they send it back to us. Right now the industry due to our vigor in getting through all these, industry has 1,800 applications with them that they are trying to respond to and send back in. Well, that is a lot of applications and they aren't going to be able to send them all back in a month.

So what we think is over the next few years, if GDUFA II is reauthorized we will get into a steady state. And you put an application in and you have a predictable path, you know when you are going to get it back. If it isn't approved, you will have time you can rapidly work on it, send it back in a couple months and it will be fixed. Now if, and if I may go on.

Mr. GUTHRIE. Go ahead, yes.

Dr. WOODCOCK. What if they have a plant somewhere that has been found to have problems, now that may take longer to remediate especially if very serious deficiencies were identified. So there are going to be some outliers where they can't really send it in again until the issues with their manufacturing or some other serious issue is remediated.

Mr. GUTHRIE. Are the multiple review applications, are they typically from smaller companies or newer companies or with less experience, or does experience and company size not matter?

Dr. WOODCOCK. We have found them from everybody.

Mr. GUTHRIE. OK.

Dr. WOODCOCK. So there is a lot of educational work to be done.

Mr. GUTHRIE. Are there any particular characteristics of applications that come through on the first cycle that you say, well, these are characteristics that could be expanded throughout the rest of the, people having issues with that?

Dr. WOODCOCK. Yes, and we are making a great effort to try and identify that and have standardized tables and more standardized submissions and so forth so that industry knows, have we filled everything out, is everything complete, is it all in here? We are doing more on the refusal to file so they get it back quickly, and it isn't filed so they can make sure it is complete before they get in the process and have to wait 8 months. So we agree with you. If we could identify those characteristics, we could help the applications be more complete.

Mr. GUTHRIE. Yes. Well, I wanted to help you and help everybody work better. That is why we are here. So does FDA currently expedite resolution of an inspection related issue when it is the only obstacle for generic approval particularly if the case is priority submission? So do you expedite inspection related issue?

Dr. WOODCOCK. We may expedite ones that are straightforward but, you know, we are dealing with fraud sometimes, we are dealing with very serious deficiencies, say, with sterility of drugs and so forth, and those have to be remediated by the sponsor before we could responsibly approve the drug.

Mr. GUTHRIE. Absolutely. We don't disagree with that. Well, thank you, you answered my questions. I yield back almost a minute of my time.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from New Jersey, Mr. Pallone, the ranking member of the full committee, 5 minutes for your questions, please.

Mr. PALLONE. Thank you, Mr. Chairman.

Dr. Woodcock, I wanted to ask you about the abuse of REMS. I believe with many of my colleagues on the committee that we should encourage and support robust generic competition in the marketplace, however, if we are to achieve this goal we must ensure that we are limiting barriers to generic entry wherever possible. Unfortunately, there is evidence that some brand drug manufacturers are using REMS programs to delay competition by preventing generic and biosimilar manufacturers access to samples of branded drug products and these samples are needed by generic and biosimilar manufacturers to conduct the bioequivalence studies needed for FDA approval.

So my question is, you note this problem of certain brand companies delaying or denying generic companies access to reference products in your testimony, can you discuss further how REMS programs are being inappropriately used to delay generics' entries to the market and what steps the agency is taking to curb those abuses?

Dr. WOODCOCK. Well, the REMS programs and other restricted distribution programs restrict general access to the drugs in some cases. And so a generics company would have to get the drug in order to compare it in a bioequivalence study and also compare back, reverse engineer the product so they are making a copy. And

in many cases they have been denied access to the drug and so they are not able to do those things.

The steps we have taken, we are willing to review the protocol of the generic and send a letter to the brand saying, this is an appropriate use for the drug and it is under, you know we have looked at it, so that there isn't a reason that says, well, we are worried these people are irresponsible and they are going to take our drug and do something.

We have made it clear that drugs even under REMS can be used for bioequivalence studies and so forth, but we can't compel companies to give their drug away to a competitor, to a generic competitor. We have also talked to the FTC about this general issue and, you know, had shared conversations with them.

Mr. PALLONE. Well, are there other tools or authorities that you need or you suggest to address the abuse? You said that you can't compel, but should we be legislating something?

Dr. WOODCOCK. I don't know the answer to that. But I know it is a problem that we struggle with a lot and that the companies struggle with and it has delayed availability of generics.

Mr. PALLONE. And I was going to ask you this, but I think you answered the question. But let me just say that you seem to think that there is, the argument is made that REMS drugs have high risk profiles that make it unsafe for generic companies to be able to access them for purpose of development, but I think your answer to that is not really.

Dr. WOODCOCK. Yes. And we are willing to look at the protocols under which they are going to be tested and tell the brand company that we find these acceptable uses.

Mr. PALLONE. OK. All right, let me move to the priority review. Prescription drug costs in this country continue to soar, and the examples of Sovaldi, Daraprim, and EpiPen have all highlighted the very real problems. I believe that we would all agree that expediting access of generic drugs is one way we can help to address high drug costs. On average the cost of a generic drug is 80 to 85 percent lower than the brand name.

So my question is prioritizing the review of first generics and sole-source generics is one way the agency can help ensure there is competition, can you please discuss how the agency currently prioritizes the review of generic drugs and how the timeline for review of an application that is prioritized differs from a standard generic drug application?

Dr. WOODCOCK. We prioritize first generics, shortage drugs, drugs under PEPFAR, and certain other categories where, say, there is a sole-source drug, and we shorten the time that we expect to get done to 8 months. So we move them through more quickly kind of like the express lane at the supermarket, OK, so we do prioritize those.

Now it is quite possible that it might be difficult to shorten those timelines more, and the reason for that is the inspections that have to be done. We have to do inspections, and in fact the generics typically have many more establishments in their application than a brand application has and they might be all over the world. And if we haven't been there in a certain amount of time based on a risk based assessment we need to go do an inspection.

Mr. PALLONE. And is this why under GDUFA II the FDA and industry have agreed on this 8-month priority review for certain applications? I mean, how do you get that 8-month review timeline?

Dr. WOODCOCK. Well, it is gotten by we need to have enough time in which to do inspections in different countries, if necessary. And why is that? Why would we want to make sure we had done inspections? Well, recently, for example, we have had cases where testing labs actually switched the samples like this so that the results would come out similar, because you are supposed to be similar and it wasn't going to be similar. So they switched samples so that they would get the right results.

We have had other cases where people are going to release their drug based on their own specifications and they found it wasn't going to meet the specifications so they made up new test results. So our obligation is to if we approve a generic drug in the United States, the public needs to know it is going to work the same as the brand drug it replaces, and that is why we have to go and do inspections sometimes. Now if we have been in the facility recently then we might not have to do that. And so we only do it on a risk base, based on whether we have been in there and other considerations.

Mr. PALLONE. All right, thank you. Thank you, Mr. Chairman.

Mr. BURGESS. The chair thanks the gentleman and the gentleman yields back. The chair recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for your questions, please.

Mr. BILIRAKIS. Thank you, Mr. Chairman. And I thank you, Dr. Woodcock, for being here, appreciate it so much.

A couple of years ago Turing Pharmaceuticals took an off-patent drug that treats HIV patients, Daraprim, and raised it by a price of 5000 percent. Unfortunately, this was not a standalone situation. Since then we have seen other drug companies, Valeant and Mylan, take old drugs and raise the price because of a lack of competition in the marketplace.

I have heard there were about 150 off-patent drugs that exist where we could have a generic, but no generic company has chosen to enter those markets. Is 150 an accurate number? What are some of the reasons for that kind of situation?

Dr. WOODCOCK. Our understanding right now is there are 182 drugs that are off-patent and have no generics competition and there may well be other generics that are sole-source where the innovator has withdrawn, because right now there are 546 drugs where the brand name has withdrawn from the market and some of those may only have one generic.

So if you lump them all together we call them sole-source products, they only have one source. And the reasons for that we believe are mainly market reasons that companies don't think it is worth their return on investment, they don't think if they enter that market they would make money compared to other opportunities they might have to make money. And so many of them have small markets and so forth. For example, we recently, there were recently drugs that have, you can file a generic now, and we had nine generics file for one and we had 16 file for another.

So where there is a big market there is a great interest, right, in getting a generic, but these small market drugs maybe that are

seen as, not a good income stream or maybe they will be overtaken in a number of years, there isn't as much in trust.

Mr. BILIRAKIS. Thank you for that. Do you know the size of the generic filing backlog and how old are some of the filings?

Dr. WOODCOCK. There is no backlog in the filing.

Mr. BILIRAKIS. No backlog?

Dr. WOODCOCK. Correct. Yes, there hasn't been for some time, that is right. So they are filed within, we are given a certain time period to do the filing review and we have no backlog within that. Yes, there was at the beginning of GDUFA that we eliminated.

Mr. BILIRAKIS. OK, thank you very much. In your testimony you talk about the approval process. You have 8 or 10 months to review an application and if they are deficient you issue a complete response letter. How long does it take for a company to respond?

Dr. WOODCOCK. That is highly variable. And right now, as I said earlier, I believe it is longer than it will be in the future because we did have that backlog of applications. We got a lot of them through our system. We sent them back to the companies. Right now there are 1,800 applications at the companies and, you know, that is a surge of responses. They are going to have to prioritize those and get the ones they deem most important back to us first. So we don't control the time where they are back with the companies.

Mr. BILIRAKIS. But on the average how long would you say?

Dr. WOODCOCK. Well, because it is a moving target, it was different before GDUFA and it has changed during, I think it is really hard to say. Ideally, it would only be a few months unless there are facility problems where a facility must be remediated, or we have seen some major problem, say, with the data where they have to go back and reverify it or redo it and those would be much longer.

Mr. BILIRAKIS. A company that is into its fifth review cycle, how many years old could that application be assuming everyone used their full time allotted in each section what would you say?

Dr. WOODCOCK. It is really hard to say, but——

Mr. BILIRAKIS. Can you give me any specific examples?

Dr. WOODCOCK. Well, it might be 5 years, say, it could be 5 or 6 years——

Mr. BILIRAKIS. Five or six years.

Dr. WOODCOCK. Under review, yes.

Mr. BILIRAKIS. Thank you very much. Well, you know what, I will probably yield back, Mr. Chairman, because my next question is very long. Appreciate it. We will submit it for the record, I appreciate it. I yield back.

Mr. BURGESS. The chair thanks the gentleman and appreciates his consideration. The chair recognizes the gentleman from Oregon, Mr. Schrader, 5 minutes for questions, please.

Mr. SCHRADER. Thank you, Mr. Chairman, and I appreciate Dr. Woodcock being here, and thank you for FDA's attention on this and working with the committee. Nice to see a process in general working very well and everyone willing to make it work hopefully even better and I appreciate your participation.

Pretty impressive with the backlog being reduced 90 percent in a 5-year time span. Wish we could do that in a lot of other areas

in government these days. But I am curious about, the terminology acted on, in terms of reducing that backlog. What percentage of that backlog constitutes new applications, maybe reapplications, people that didn't even have a good application to begin with, that you couldn't even begin to make substantive comments on, do you have that breakdown for the committee?

Dr. WOODCOCK. Yes, it is a pretty substantial percentage. Keith, do you know the number? OK, we can get back to you on that but there is a pretty substantial percentage of that, quote, backlog that couldn't be approved or tentatively approved the first time and required going back to the company and then resubmission.

Mr. SCHRADER. So most of it is just normal, what you would call perhaps normal, didn't quite get it all right, please fill in the blank?

Dr. WOODCOCK. Correct. That is correct.

Mr. SCHRADER. All right. So what about just, have you given any thought—you have done a lot of good work with preapplication processes and all that. How about just an education session, I mean, particularly for the small outfits that just don't have the team of lawyers or whatever to work through or read all these Web sites? They are just trying to do the Lord's work. Is there an opportunity for folks to tune in to an education session once or twice a year about here is what you need to do and here is some of the common problems we see?

Dr. WOODCOCK. Yes, and we do that routinely and a tremendous amount. And also we issue guidances on most new reference drugs that come out, the brand drugs, and so we will issue guidance well in advance on how to develop a generic for that.

Mr. SCHRADER. Well, I am not talking just guidance, I am talking about a real person, sitting down.

Dr. WOODCOCK. Oh, we do. So we have webinars. We go to the technical meetings of the associations. We do gather up common deficiencies and we post lists of these and we are really trying. But we think it will take, we are seeing improvement. We are up to nine percent, right, of first-cycle approvals with the new ones, but we think it will take time. We don't like cycles either because it increases our work. It slows time to access and it just clogs up the system. But we will, I agree, education is the key to get—and also our refusal to file, we list all the reasons.

Mr. SCHRADER. So with all that again each of my colleague Congressman Bilirakis' point, if you are doing all this or there seems to be, I think, a number of cycles that we should allow the reapplication for and then maybe cut it off.

At some point, if you are doing all the up-front work and everyone agrees you are doing the education, plus the guidance, plus the review, at some point so the backlog, you know, out of the 1,800 or whatever it is that are still in the backlog, how many have been, it would be interesting for us to know how many have been through one cycle, two cycles, three cycles to get to the average or whatever, because there is some due diligence on a company's part, to not waste your time or the taxpayers' dollars.

Dr. WOODCOCK. Yes. Well, we could certainly provide you with what statistics we had. As part of getting this whole program up and running we have put in a new IT system that tracks the proc-

ess from soup to nuts so to speak. And we can get reports out of that and I am trying to get these reports by cohort, like the class of '13, the class of '14, the class of '15, what happened to them, how many cycles.

Mr. SCHRADER. That would be really helpful.

Dr. WOODCOCK. Yes. So we are very interested in that too and we can provide you with what information we have on that.

Mr. SCHRADER. I guess then the last comment I make, Mr. Chairman, is that, our bill, we are really trying to target those lifesaving medications. These are medications that aren't just a public health priority which you already prioritize, but these are, immediate either acute or chronic health care lifesaving medications we are trying to accelerate to market.

And generally the ones we are talking about aren't very complex, wouldn't take hopefully FDA's resources to an extreme, and many can be manufactured right here in the United States to decrease that global footprint you talk about that would really require a lot of time. And I think that is the rationale between our bill trying to make sure that that is the top priority because it is lifesaving and has to be done almost immediate.

And I appreciate your efforts on our behalf, and I yield back, Mr. Chairman.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman, and the chair recognizes the gentleman from Missouri, Mr. Long, 5 minutes for questions, please.

Mr. LONG. Mr. Chairman, today we are discussing issues of competition and ways we can improve drug development to lower cost in the private drug market. On that theme and before I forget, I would like to ask unanimous consent to enter into the record a letter from the FTC to CMS outlining ways in which we can best maintain a system of competition and transparency between providers and payers in this market.

Dr. Woodcock, to promote the goal of achieving first-cycle approvals and approvals on the earliest legally eligible date, the industry has placed a focus on increasing transparency and communication during the review process. Under the current agreement, how often and at what stages of the review and approval process does FDA communicate with the applicant?

Dr. WOODCOCK. Well, we usually don't communicate with a technical matter with the—well, let me start again. There is a process called controlled correspondence. That was part of GDUFA I agreements and we had a backlog of that. OK, we are totally caught up with that and we answer all these. These are inquiries from sponsors that are written that we can answer about their application and we send those back. And we get hundreds of those every year, so we are in written communication.

But right now we do not really have meetings and those type of communications with applicants prior to——

Mr. LONG. So you are not getting any type of feedback or anything from the applicants?

Dr. WOODCOCK. Not currently. That is not how the process was set up.

Mr. LONG. OK.

Dr. WOODCOCK. However, the proposed GDUFA II for the complex generics will set up more processes that we can talk to the applicants beforehand. For the more simple generics, which are many of them, the guidance that we put out before they start making their product should provide all the information they need on submitting an application and what they need to do. It is basically a cookbook.

Mr. LONG. OK. With that I yield back, Mr. Chairman, thank you.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. ESHOO. Thank you, Mr. Chairman. And Dr. Woodcock, it is nice to see you again. Even though he left awhile ago, I want to publicly acknowledge the kind and generous remarks of Congressman Joe Barton relative to the biosimilars legislation that became part of the ACA. It was a big vote in the full committee here, 47 to 11. It was Senator Kennedy's legislation in the Senate and his Republican sponsor was Senator Orrin Hatch.

So when I hear the steps being taken to fulfill what we set out to do, it was to bring biosimilars forward essentially in the form to create a generic biosimilar. And so that was a while ago. We passed the ACA several years ago, so the implementation is slow but each step is very important.

Dr. Woodcock, I read all 24 pages of your written statement last evening, and I think that what I drew from it is the following that progress is being made on several fronts. I think that when we talk about hiring freezes and words that are very familiar around the Congress, they start losing their meaning. They start losing their meaning, because if in fact, which you have the agreements that you have entered into with industry partners on user fees for both of these reauthorizations, if you don't have the staff, forget the timing of these applications or the timeliness of when these applications can really get to market.

So I don't know if, well, I hope that there will be advocates from the majority that will point this out to the administration, because I think every question and comment today with the exception of what Mr. Pallone said in the beginning about will there/won't there be a hearing next week, or a markup next week, they have all been tied to timeliness. And so I just want to underscore that.

I also want to add something else to this, and that is that these user fees are private sector dollars. And all of this business with sequester, I did legislation on it so that the FDA would be able to have access to those dollars and it made it all the way up to the conference committee and someone pulled it out.

But I still think that it is very important, it is something that is very important to appreciate. And so those private sector dollars should not be treated the way the public sector dollars are treated, and I think FDA is more than entitled to use those dollars as a result of the user fees in order to accomplish all the things that you wrote about in your 24-page written statement.

I want to turn to something that I have been pursuing, well, now it is more than a couple of years. We all know that the FDA plays a critical role in protecting the health of all Americans, but all the members of this committee may not be aware that there is an FDA

Office of Women's Health. And it was established by an act of Congress in 1994, and I think it demonstrates the impact, the importance that the FDA and Congress placed on ensuring that the FDA adequately considers the impact of its decisions on women, which leads me to sodium oxybate.

This is an important drug but it is also a dangerous drug. It is also a dangerous drug if it gets into the wrong hands. Well, I think that we all feel that we read too many stories today about sexual violence against women and there are, it is just the list goes on and on. But what I want to pursue with you—and I have a stack of letters. It is like we are pen pals. I am not satisfied on the following front and that is that as the drug moves to a generic version that the word safety with a big red stamp can honestly be placed on the generic. And you know that I have had misgivings about it.

What I would like to ask you today, because there is not a lot of time—I have a minute and, oh, I think I have gone over—is to ask you to make a commitment today to me to meet with me and the women advocates that care so much about this. Would you be willing to do that?

Dr. WOODCOCK. I am happy to do that.

Ms. ESHOO. All right, that would be great.

Thank you, Mr. Chairman, for your indulgence.

Mr. BURGESS. The gentlelady yields back. The chair thanks the gentlelady and recognizes the gentleman from North Carolina, Mr. Butterfield, 5 minutes for questions, please.

Mr. BUTTERFIELD. Thank you very much, Chairman Burgess. Thank you for holding this very important hearing today. These agreements that we are talking about, Mr. Chairman, are so important to improving public health and they represent good faith negotiations between the prior administration and industry. They show the way that the FDA should work and it is my hope that the current administration does not stand in the way of progress.

The advances in biologics and generics have been quite significant and generics have saved our healthcare system nearly $1.5 trillion over the last 10 years. Biologics have helped develop treatments for serious diseases like rheumatoid arthritis. It is important that we continue to build on this progress by supporting the FDA's agreement with industry.

However, it is highly concerning that this administration seems to not understand the challenges facing FDA in ensuring safety while working with industry to approve treatments. The administration believes that the process at the FDA is, quote, slow and burdensome, end of quote, despite a record year of generic drug approvals or tentative approvals in 2016. It is critical therefore that the administration respect these agreements and ensure that the FDA has all of the resources that it needs to review these important treatments.

If the administration truly wants FDA to protect public health and fulfill its mission, it should not implement a hiring freeze that could prevent the replacement of key personnel. Now is the time to staff up at the FDA and other agencies as well whose mission it is to work for the betterment of public health. It should also follow through on Congress' promise to provide additional resources to the FDA as this committee did through the 21st Century Cures

Act. Lastly, the administration should nominate an FDA administrator committed to the agreements reached with industry and not someone who wants to simply accelerate drug approval without concern for safety and efficacy.

Dr. Woodcock, thank you for your testimony. Thank you for the FDA's efforts to reach these agreements with industry, and I appreciate your explanation of how additional resources were important in implementing the first act. Do you agree or disagree that the additional 1,000 new employees hired during the first agreement helped increase the FDA's responsiveness to these applications?

Dr. WOODCOCK. Absolutely, they were essential. And that is part of, first, our agreement and then our track record that we have succeeded with this program.

Mr. BUTTERFIELD. At the end of January, Democratic leaders on this committee sent a letter to the administration asking for clarification about the January 23rd executive order implementing the freeze. In that letter they asked whether federal hiring for programs supported by user fees at the FDA would be subject to the freeze or if those programs might be eligible for an exemption from the executive order. I am concerned that this executive order could in fact make it more difficult to implement these agreements and respond to the applications.

Can you please describe the potential impact of the executive order on the generic and biosimilar user fee agreements?

Dr. WOODCOCK. Well, as I said earlier, we are working with the administration and we hope we can move forward on all these programs. But we are working closely with the administration now.

Mr. BUTTERFIELD. All right. Well, I wish you the best of luck on that. Dr. Woodcock, you described significant challenges in hiring staff who can address the complexity of biologics. How can the additional hiring authority in the 21st Century Cures Act help with that? Does the executive order compromise any of those hiring authorities?

Dr. WOODCOCK. Well, I want to thank the committee for their work on 21st Century Cures. I think it is a good step forward. We are working on planning the implementation of the various provisions within 21st Century Cures and we hope to continue to move ahead on that.

Mr. BUTTERFIELD. All right. All right, like Mr. Bilirakis said a few minutes ago, my last question would consume the time and so I am going to yield back. All right, thank you, Mr. Chairman.

Mr. BURGESS. The chair thanks the gentleman. The chair recognizes the gentleman from Oklahoma, Mr. Markwayne Mullin, 5 minutes for your questions, please.

Mr. MULLIN. Thank you, Mr. Chairman. And Dr. Woodcock, thank you so much for being here. I know you are doing the best you can underneath the circumstances and I really appreciate your focus on industry. I mean that is where it starts.

A big focus I have is obviously watching over small businesses too, and one of the concerns I have, or the primary concerns, really, I have is over the GDUFA—am I pronouncing that right, by the way? These acronyms we have up here sometimes might be easier to explain them rather than to say them—was it didn't provide any

relief for small businesses. Do we believe on the second GDUFA it is being addressed?

Dr. WOODCOCK. It is being addressed in two ways. One, for the first filing people will not have to pay fees if they are not on the market for their manufacturing facility. Those were the people who were the hardest hit, those who hadn't a contract for manufacturing. And then the fees are going to be tiered. There is a different fee depending on the volume in the various company programs, so there is various tiers.

So we were very conscious of the small business and also the different size of the businesses. And we tried to craft with industry the fee structure in a way it would be fair to everyone.

Mr. MULLIN. Thank you. And another concern we have been hearing is the inconsistency on the FDA inspections. Some businesses we have heard have been put on hold. Are we addressing that?

Dr. WOODCOCK. The FDA is going through a huge reorganization of our field force, which is not the Center for Drugs, it is the Office of Regulatory Affairs which houses all our inspectors or our field inspectors, and they expect in May to go into a reorganization at which time they will have a pharmaceutical inspectorate. In other words, a group of individuals who will solely inspect drug manufacturing facilities instead of, you know, inspecting foods maybe and the devices and so forth.

And so we hope to have a very close relationship with them. We have worked out a new process by which these facility evaluations will be done between us and we hope that one of the big payoffs is going to be a great deal more consistency in how we approach these facilities.

Mr. MULLIN. With these field inspectors do they have SOPs, standard operating procedures?

Dr. WOODCOCK. They do. They have compliance policy guides they call them which guide how you do an inspection and so forth, but we are also working on what we call the new inspection protocol which will be much more of a checklist type of thing. We are piloting that now.

Mr. MULLIN. One of the most frustrating things and the reason why I am really focused on this, especially with those businesses that have been put on clinical holds, as a small business owner myself it is imperative that I deliver the same product over and over and over again. And I am in the service industry and we have well over 150 individuals that work with us and we are constantly trying to improve our operating procedures.

But when you have people that had the authority that the inspectors do and they are inconsistent in delivering that, just standard operating procedures seems like that that would clarify so much that we have in bringing clarity to and surety to those that they are going in and inspecting. And I get that you have a new field staff, but surely there is ways that we can help, we can work together with bringing consistency to the industry, because the last thing we need is inconsistency on something that is so important with the Food and Drug Administration.

Dr. WOODCOCK. Well, I agree with you. And actually yesterday marked a landmark where we signed a mutual reliance agreement

with Europe over working to rely upon their inspections in Europe and they would rely on ours in the U.S. And to do this internationally, which will really help on speed that we have been talking about today and help leverage other inspectorates, we need to move toward common procedures so that——

Mr. MULLIN. Agreed.

Dr. WOODCOCK [CONTINUING]. We can understand what each other has done and feel comfortable relying on it. So we are working in that international area too. But I completely agree with you, and we are actually working on, underneath our concept of operations we have put forward for the new structure we are working on SOPs. That is the next step.

Mr. MULLIN. Thank you. And if I can be of any assistance to you in it, please let me know.

Mr. Chairman, I yield back.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman and the chair recognizes the gentleman from Georgia for 5 minutes for questions, please.

Mr. CARTER. Thank you, Mr. Chairman. Dr. Woodcock, good to see you. Thank you for being here. We appreciate your participation in this. As I understand it, the generic drug user fee act was designed to speed up access and that you were going to get help from the companies, from the manufacturers, the generic manufacturers in order to speed up that process and it was somewhat of a trade-off. And I think the original idea was good and certainly to a certain extent it has worked.

But let me ask you, of the 6,000 outstanding abbreviated new drug applications what percentage of those would you say have begun the process of being reviewed by the FDA?

Dr. WOODCOCK. All.

Mr. CARTER. All of them have begun?

Dr. WOODCOCK. Right. Well, first of all, I am not sure where the 6,000 comes from. There was 2,800 and some right before the program started and then we have gotten a certain number each year, up to a thousand each year since the program started. But meanwhile we are approving some, you know, all during that period as well.

Mr. CARTER. OK. What can we do to help you? What can Congress do? Tell me what we can do in——

Dr. WOODCOCK. You can probably pass GDUFA II, OK.

Mr. CARTER. OK.

Dr. WOODCOCK. Because what you are maybe hearing, all right, is that the old applications, the ones that were sitting there well before this program started, when they come out they are going to be 5 years old because they were sitting around all that time.

Mr. CARTER. Sure.

Dr. WOODCOCK. But the ones, say, next October, if you pass this legislation or something near it, the agreement is in 10 months, you send in a good application, in 10 months you are on the market. And we hope as many as possible will get that first-cycle approval, either tentative approval or full approval, depending on the patent status so that they are off our plate, OK, they are done. And we hope to continuously improve that over the next 5 years so that

by the end of that time most of the applications would go through and be out on the market.

Mr. CARTER. OK. I trust you and I hope you are right and I hope that is the scenario that plays out.

Hang with me for just a second. As you know, I am the only pharmacist currently serving in Congress and I am under a lot of pressure trying to answer what is going on with prescription drug pricing, why are these drugs going up? We have had instances over the past 2 years that I have been a member of this August body where we have had bad actors in the marketplace, where we had Turing Pharmaceuticals, where we had Valeant, where we had Mylan.

And now we have, just recently we had this drug come out, deflazacort, that is going to be marketed as Emflaza by Marathon Pharmaceuticals. Interestingly enough, I just recently found out that that CEO was also involved in the Valeant case. So, this is not something new with him.

My question is this. I have had compounding pharmacies come into my office and tell me we could have helped in that situation particularly with the situation with the Daraprim in Turing, that they could have marketed that but they needed FDA to give them that authority to do that and they couldn't get it. FDA can help us in these situations where these rogue companies, if you will, have us by the short hairs and we cannot do anything about it. We have the ability out there.

And I know the safety part of it is extremely important. I respect that and I am very sensitive to it, but at the same time, I think it is irresponsible of us—and I say us being government and the FDA. I put us in the same bucket there. I think it is irresponsible of us not to at least attempt to do something about that.

Dr. WOODCOCK. Well, we are happy to work with Congress. There is a range of options that people brought up and we are willing to work with Congress.

Mr. CARTER. OK. Well, see, that is what I am telling you. That is what the people coming in my office are telling me is that they had an alternative to the Daraprim, but they couldn't get it approved through you to get it marketed.

Dr. WOODCOCK. Well, yes, we don't approve compounded drugs. That is mainly under state as you know, but there are a number issues probably too complicated for a 5-minute conversation.

Mr. CARTER. Exactly.

Dr. WOODCOCK. But we are certainly, the issue sole-source or only a few source drugs where then they are vulnerable to market, you can rise up the prices easily——

Mr. CARTER. Exactly.

Dr. WOODCOCK [CONTINUING]. Is a problem that many people are trying to address. As I said there are 182 drugs that we know of that are off-patent and have no generic competition right now.

Mr. CARTER. And let me, we need to address that because that is not the way the system was set up and that is not the way the free market ought to be working. Those drugs ought to have generics as soon as they come—what is causing that, do you know?

Dr. WOODCOCK. We believe that there are market forces. It is not attractive enough to be a competitor. It is a small market or has

some other characteristics where the generics are not interested. This has been going on for years, so the people had plenty of opportunity to submit generic applications but they haven't.

Mr. CARTER. And that seems to be what we are headed toward that what the Emflaza is doing, I mean, this is for Duchenne muscular dystrophy. I mean, you know, they have a limited market that they are catering to and we need to make sure those patients, and they need it now. They can't wait.

Dr. WOODCOCK. Well, that drug is newly approved in the United States so it is protected by various exclusivities.

Mr. CARTER. But that drug has been being used in Europe for years.

Dr. WOODCOCK. I know.

Mr. CARTER. And it is just much, much less than what they are going to be charging for it in America. Now that is outrageous. I don't like the federal government being involved in anything, but we need to step in there. That is wrong.

Dr. WOODCOCK. So that is the situation. So there are some brand drugs that have pricing issues in people's minds and then there are generic drugs or brand drugs that actually could have generic competition that don't have them.

Mr. CARTER. I can accept it to a certain extent if it is innovative, but that is not innovation. That is just bringing something over here and playing the market.

Dr. WOODCOCK. Sure.

Mr. CARTER. Mr. Chairman, I apologize. I know I went over my time and I yield back.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman.

Dr. WOODCOCK. Mr. Chairman.

Mr. BURGESS. Yes.

Dr. WOODCOCK. I misspoke earlier in my oral. Could I just give you a very brief correction?

Mr. BURGESS. Great, sure.

Dr. WOODCOCK. Thank you. I said we have approved 56 first generics. What I meant is in the backlog cohort only there were 56 that we have approved, all right. We have approved 405 first generics overall during GDUFA I. So it is in my testimony but I just wanted to correct the record here. Thank you.

Mr. BURGESS. Very well, and we appreciate you being here with us, Dr. Woodcock. We are not going to recess, but immediately transition into our second panel of witnesses who we thank for being here today and taking the time to testify before the subcommittee. Again Dr. Woodcock, thank you for your testimony. As a reminder, each witness will have the opportunity to give an opening statement followed by questions from members.

So the committee will come back to order. Again I want to thank our second panel of witnesses for being with us today and appreciate their indulgence.

Our second panel of witnesses today includes Mr. Allan Coukell, Senior Director of the Health Programs at Pew Charitable Trusts; Mr. David Gaugh, Senior Vice President of Science and Regulatory Affairs, Association for Accessible Medicines; Mr. Bruce Leicher, Senior Vice President and General Counsel of Momenta Pharma-

ceuticals and Chair of the Biosimilars Council for the division of the Association of Accessible Medicines; Ms. Juliana Reed, vice president of Government Affairs, Coherus Biosciences, and immediate past president of the Biosimilars Forum; and Ms. Kay Holcombe, senior vice president of Science Policy, Biotechnology Innovation Organization. We appreciate all of you being with us today. We will begin our panel with you, Mr. Coukell, and you are now recognized for 5 minutes for an opening statement. Thank you.

**STATEMENTS OF ALLAN COUKELL, SENIOR DIRECTOR OF HEALTH PROGRAMS, THE PEW CHARITABLE TRUSTS; DAVID R. GAUGH, R.PH., SENIOR VICE PRESIDENT FOR SCIENCES AND REGULATORY AFFAIRS, ASSOCIATION FOR ACCESSIBLE MEDICINES; JULIANA REED, VICE PRESIDENT OF GOVERNMENT AFFAIRS, COHERUS BIOSCIENCES, IMMEDIATE PAST PRESIDENT OF THE BIOSIMILARS FORUM; BRUCE A. LEICHER, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, MOMENTA PHARMACEUTICALS AND CHAIR OF BIOSIMILARS COUNCIL, ASSOCIATION FOR ACCESSIBLE MEDICINES; AND KAY HOLCOMBE, SENIOR VICE PRESIDENT, SCIENCE POLICY, BIOTECHNOLOGY INNOVATION ORGANIZATION**

**STATEMENT OF ALLAN COUKELL**

Mr. COUKELL. Thank you, Mr. Chairman, Ranking Member Green, and members of the subcommittee. I appreciate the opportunity to present testimony. Pew is a nonprofit, nonpartisan research and policy organization with programs that touch on many areas of American life. I was asked today to focus on the challenge of rising pharmaceutical costs within the user fee context and beyond it.

As you know, drug spending in the United States topped $300 billion in 2015. That is up nine percent just in that year alone. That is faster growth than the rest of health care and it is a trend that strains budgets and helps drive up insurance premiums and the cost of Medicare and other taxpayer-funded programs. It also hits consumers in the pocketbook, and three-quarters of Americans say that prices are unreasonable.

The evidence suggests this is not a short-term fluctuation but a long-term trend, a trend that is driven largely by the rising cost of new medicines especially high cost specialty drugs that are used by only one or two percent of the population but account for about a third of drug spending. Some of these products are exciting therapeutic advances, true breakthroughs, some are not, but they are reaching market at ever higher launch prices, and year-on-year increases in price after launch are another major contributor to rising drug spending. A number of generic drugs have also undergone steep price hikes, but in general generic prices as a category remain flat or falling.

So what can be done in response? Well, changes to FDA's approval process may offer some potential to address drug spending, many key opportunities lie elsewhere. Generic competition has long been the main tool to manage drug prices in the United States, and

the first GDUFA agreement has helped to reduce the backlog of pending applications.

Other potential areas for efficiency include policies to ensure that generic companies have access to brand name products for bioequivalence testing, policies to limit so-called pay-for-delay settlements that in some cases cause anticompetitive delays in market entry. The Lower Drug Costs Through Competition Act would award a generic priority review voucher to manufacturers who bring drugs to market in cases of limited competition or a drug shortage and would establish a 6-month timeline for FDA review of priority applications compared with the 8-month priority review goal in GDUFA II.

It is important to note that FDA does already prioritize generic applications when there is only one competing product, so the net benefits and practical feasibility of a 6-month review are a little bit unclear. Perhaps more important than shortening the duration of review is reducing the number of review cycles. And I commend the FDA and the industry for their shared commitment in GDUFA II to improving first-cycle success rates.

When focusing on measures to increase competition, we should note that the biologic drugs which are a big driver of increased spending won't be affected by changes in the generic approval process. However, anything that hastens biosimilar development including better aligning the exclusivity for biologics and small molecules would help to reduce spending. There are also potential ways to increase competition among drugs that are already on the market.

There are well established tools in the commercial insurance market, tools like formulary placement and prior authorization that are absent or limited in parts of the Medicare program and consideration could be given to policies that would increase competition within Medicare Part D and Part B and potentially shift some drugs from one program to the other. More broadly, factoring value into coverage decisions including the choice not to cover a drug whose cost isn't justified will help reduce overpayment for marginal clinical gains, and Congress could take steps to help advance this alignment.

Finally, there are opportunities to improve transparency in purchasing. Pharmacy benefits managers negotiate deep discounts from drug companies on behalf of their employer and insurance clients, but these contracts can be extremely complex making it difficult for even the sophisticated clients to determine whether they have achieved an optimal share of savings. Congress could consider requiring greater transparency of contract terminology and definitions between payers and PBMs as well as mandating the ability to audit these arrangements.

The balance between access to innovative medicines and constraining cost growth is a long-term challenge with no single solution. In striking the right balance, Congress should look both within and beyond the user fee agreements. I thank you for holding this hearing and welcome your questions.

[The prepared statement of Mr. Coukell follows:]

**Testimony before the**
**Committee on Energy and Commerce**
**Subcommittee on Health**
**United States House of Representatives**
**March 2, 2017**
**Allan Coukell, Senior Director of Health Programs, The Pew Charitable Trusts**

Chairman Burgess, Ranking Member Green, members of the sub-committee, thank you for holding this hearing and for the opportunity to present testimony.

Pew is a nonprofit, nonpartisan research and policy organization with programs that touch on many areas of American life. I have been asked to focus today on the challenge of rising pharmaceutical costs, within and beyond the user-fee context.

Drug spending in the United States rose nearly 9 percent in 2015, to more than $300 billion per year[1] and surveys show that three-quarters of Americans think prices are unreasonable.[2]

This would not be an issue if health budgets could rise indefinitely. But drug spending is rising faster than the rest of healthcare spending.[3] This hits consumers in the pocketbook, and helps drive up insurance premiums and the cost of Medicare and other taxpayer funded programs. All the evidence suggests this is not a short-term fluctuation, but a long-term trend.

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[1] IMS Institute for Healthcare Informatics, "Medicines Use and Spending in the U.S.: A Review of 2015 and Outlook to 2020," April 2016, Available at: http://www.imshealth.com/en/thought-leadership/quintilesims-institute/reports/medicines-use-and-spending-in-the-us-a-review-of-2015-and-outlook-to-2020

[2] Kaiser Family Foundation, "Kaiser Health Tracking Poll: September 2016," September 2016, Available at: http://kff.org/health-costs/report/kaiser-health-tracking-poll-september-2016/

[3] The Centers for Medicare & Medicaid Services projects that prescription drug spending growth will continue to outpace overall healthcare cost increases over the next decade. Source: Centers for Medicare & Medicaid Services, "National Health Expenditure Projections 2016-2025," Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf

It is largely the result of the rising cost of new medicines – especially high-cost specialty drugs,[4] which are only used by one to two percent of the population, but account for more than one-third of drug spending.[5]

Some of these products are exciting therapeutic advances – true breakthroughs – but some are not. And they are reaching market at ever-higher launch prices. Year-on-year increases in the prices of brand-name on-patent drugs are also a major contributor to rising spending.[6,7]

A number of generic drugs have also undergone steep price hikes. But in general, generic prices, as a category, remain flat or falling.[8]

**What can be done in response?**

FDA's approval processes outlined in the generic and other user-free agreements may offer some potential to address drug spending, but many key opportunities lie elsewhere. Competition – in the form of generic drugs – has long been the main tool used to manage drug prices in the United

[4] Examples include medicines for cancer, hepatitis C, multiple sclerosis, rheumatoid arthritis and other autoimmune conditions.
[5] Express Scripts, "2015 Drug Trend Report," 2016.
[6] Pharmaceutical list prices can often increase by more than 10 percent annually, though payers have negotiated larger rebates with manufacturers to partially offset these price increases. Nevertheless, annual net prices are a major driving factor. Source: IMS Institute for Healthcare Informatics, "Medicines Use and Spending in the U.S.: A Review of 2015 and Outlook to 2020," April 2016, Available at: http://www.imshealth.com/en/thought-leadership/quintilesims-institute/reports/medicines-use-and-spending-in-the-us-a-review-of-2015-and-outlook-to-2020
[7] For example, older therapies for multiple sclerosis introduced in the 1990s, entered the market with list prices of $8,000 to $11,000 annually, but now these same products have list prices of more than $60,000 per year. Source: Daniel M Hartung, et al., "The cost of multiple sclerosis drugs in the US and the pharmaceutical industry," *Neurology*, 84.21 (2015): 2185.
[8] Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Understanding Recent Trends in Generic Drug Prices," January 2016, Available at: https://aspe.hhs.gov/pdf-report/understanding-recent-trends-generic-drug-prices

States.[9] The first generic user fee agreement has helped reduce the backlog of pending ANDA applications,[10] but more can be done to reduce barriers to generic entry, such as:

- policies to ensure that generic companies have access to brand-name products for bioequivalence testing,[11] and
- policies to limit so-called "pay-for-delay" settlements that can, in some cases, be anti-competitive by delaying generic market entry.[12]

Reducing review time for generic drugs at FDA would also be beneficial. The Lower Drug Costs through Competition Act (H.R. 749) would award a generic priority review voucher to any manufacturer that brings a generic drug to market in cases of limited competition or a drug shortage. It would also establish a six-month timeline for FDA review of priority applications, compared to the eight-month review goal in the draft GDUFA II agreement for priority ANDA applications. However, it is important to note that FDA already prioritizes

[9] Generics are now nearly 90 percent of all prescriptions filled, but less than 30 percent of drug spending.
[10] There was a backlog of 2,866 generic applications awaiting FDA review as of October 1, 2012, when GDUFA passed. The Agency has met its GDUFA commitment to take first action on over 90% of these applications. As of December 31, 2016, the FDA had approved or tentatively approved 842 of the 2012 backlog applications. Since the start of GDUFA implementation, the agency has met its hiring goals, but received more applications (nearly 1500 in FY14) than the 750 that were anticipated. Sources:
https://www.fda.gov/downloads/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/AbbreviatedNewDrugApplicationANDAGenerics/UCM542929.pdf;
https://www.fda.gov/NewsEvents/Testimony/ucm484304.htm
[11] Barriers to generic entry exist when brand drug manufacturers prevent generic companies from obtaining their products in order to carry out the testing necessary to develop a generic version of a drug. In some cases, FDA orders a manufacturer to develop a program to ensure safe use of a high-risk product, such as a requirement that a drug can only be acquired through select providers, or the manufacturer may independently opt for a restricted distribution network. However, some generic manufacturers allege that these provisions are used to restrict generic company access. Litigation to obtain samples for comparative testing often takes years to conclude.
[12] Brand and generic companies frequently strike "pay-for-delay" settlements that involve a brand pharmaceutical manufacturer paying one or more potential generic competitors to resolve patent infringement lawsuits and agree upon a date by which the generic product can come to market. Both the brand and generic company benefit under such agreements, while the public pays higher prices than it would were the generic available. In 2015, for example, the Federal Trade Commission (FTC) reached a $1.2 billion settlement with Cephalon, Inc. for illegally blocking generic competition to its blockbuster sleep-disorder drug Provigil, driving up costs for consumers, insurers, and pharmacies. FTC estimates that a ban on pay-for-delay agreements would save consumers and taxpayers $3.5 billion annually. However, any policy should also consider that some such settlements may be pro-competitive.

generic applications when there is only one competing product on the market (brand or "sole-source" generic). The net benefits and practical feasibility of a six-month review are unclear as is, consequently, the market value of a priority review voucher for generic applications.

Perhaps more important than shortening the duration of review is reducing the number of review cycles.[13] We applaud the shared commitment of FDA and the industry in the GDUFA II agreement to improving success rates for first cycle review.

When focusing on measures to increase competition, it must be noted that the biologic drugs that are a significant driver of increased spending will be unaffected by changes to the generic review process, because there is a different FDA pathway for approval of biosimilars. Anything that hastens biosimilar development – including better aligning biologic and small-molecule exclusivity periods – would reduce spending.[14]

**Potential to increase competition among existing drugs**

There is a set of tools that can be used to provide leverage on prices while protecting access – such as formulary placement and prior authorization that are well established in commercial insurance, but are absent or limited in parts of the Medicare program. Consideration could be given to policies that would:

[13] Woodcock J. Implementation of the Generic Drug User Fee Amendments of 2012 (GDUFA). Testimony before the Senate HELP Committee. Jan 28, 2016.

[14] There is a substantial difference in the duration of market protection provided to makers of biological drugs, which are derived from living cells, and that given traditional pharmaceuticals. Reducing the period of guaranteed exclusivity for biologics from the current 12 years to seven years would bring them more in line with traditional drugs, which typically receive five years of exclusivity. Such a change could generate more than $4 billion in savings to Medicare over 10 years. Source: Kaiser Family Foundation, "Summary of Medicare Provisions in the President's Budget for Fiscal Year 2016," February 2015, Available at: http://kff.org/medicare/issue-brief/summary-of-medicare-provisions-in-the-presidents-budget-for-fiscal-year-2016/

- increase competition within the Medicare Part B program,[15]
- increase competition within Medicare Part D,[16,17] and
- shift some drugs from the medical to the pharmacy benefit.

**An increased focus on value**

Both within public programs and in the commercial market, formal value-based or outcomes-based agreements between manufacturers and purchasers – contracts that tie the price of the drug to specified outcomes – may play an important role for some products, but the utility of such arrangements may be limited by their cost to negotiate and the need for sophisticated data systems to monitor success. More broadly, factoring value into coverage decisions – including the choice not to cover drugs whose cost isn't justified – will help reduce overpayment for marginal clinical gains.

**Opportunities to improve transparency in drug benefit contracting**

[15] The Medicare Part B program spends some $25 billion each year for drugs administered in clinics and physician offices. Policies to manage biosimilar drugs similar to the current approach for generics could create greater competition. Source: The Pew Charitable Trusts, "Can Biosimilar Drugs Lower Medicare Part B Drug Spending?" January 2017, Available at: http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2017/01/can-biosimilar-drugs-lower-medicare-part-b-drug-spending

[16] Medicare price negotiation (which is currently prohibited by statute) would achieve savings only if combined with new authority for Medicare to design its own formulary or preferred drug list, similar to how private plans prioritize certain drugs among equally effective therapies. Source: Shih C, Schwartz J, Coukell A, "How Would Government Negotiation Of Medicare Part B Drug Prices Work?", *Health Affairs Blog*, February 1, 2016, http://healthaffairs.org/blog/2016/02/01/how-would-government-negotiation-of-medicare-part-d-drug-prices-work/

[17] Independent of government price negotiation, current law requires Medicare drug plans to cover every medication within six different broad classes, such as antidepressants and antipsychotics. This policy limits the ability of privately-run Medicare prescription drug plans to negotiate lower prices. Giving greater flexibility to private Part D plans in how they design their drug benefits could improve their ability to negotiate lower drug prices on behalf of Medicare beneficiaries and the federal government. Source: Lee T, Gluck A, Curfman G, "The Politics Of Medicare And Drug-Price Negotiation (Updated)", *Health Affairs Blog*, September 19, 2016, http://healthaffairs.org/blog/2016/09/19/the-politics-of-medicare-and-drug-price-negotiation/

Pharmacy benefits managers – the middlemen that insurers and employers pay to both administer prescription drug benefits and negotiate discounts from drug companies – play a crucial role, using their large sales volumes and their ability to create formularies to force drug companies to offer deep price concessions. However, a share of the savings accrues to the pharmacy benefit managers themselves, and their contracts can be extremely complex, making it difficult even for sophisticated benefits administrators to determine whether they've achieved optimal savings.

Congress could consider requiring greater transparency of contract terms and definitions between payers and pharmacy benefit managers,[18] as well as mandating the ability to audit these deals, and ensuring that entities that advise purchasers on PBM contracts do not also have financial relationships with the PBMs themselves.

**Conclusion**

The FDA user fee agreements have done much to speed the approval of brand and generic drugs. As Congress seeks to manage the challenge of rising drug spending, it should look both within and beyond these agreements to achieve a balance between access to innovative medicines and the equally important need to constrain cost-growth in healthcare. I thank you for holding this hearing, and welcome your questions.

[18] More than two dozen of the largest U.S. corporations, including American Express, Coca-Cola, IBM, Marriott, and Verizon, have proposed greater transparency in these contracts. Source: Silverman E, "The 'gouge factor': Big companies want transparency in drug price negotiations," *STAT News*, August 2, 2016. Available at: https://www.statnews.com/pharmalot/2016/08/02/drug-price-transparency-pharmacy-benefits-manager/

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. At this point the chair would like to recognize the chairman of the full committee.

Mr. WALDEN. I thank the subcommittee chairman. I appreciate the indulgence of the committee and our witnesses. We need to deal with a slightly different matter that involves us all and I just want to clarify, because I know there have been questions that have been raised.

Reports that the Energy and Commerce Committee is doing anything other than a regular process of keeping its members up to speed on the latest developments in its jurisdiction are false. We are continuing to work on drafting and refining legislative language to provide relief from a failing law, and by that I mean Obamacare. Part of that process is giving committee members and staff the opportunity to work closely together to draft a bill that reflects the concerns of our constituents and reflects our mandate from voters to repeal and replace Obamacare. Simply put, Energy and Commerce majority members and staff are continuing to discuss and refine draft legislative language on issues under our committee's jurisdiction.

And with that I yield back to the chairman.

Mr. BURGESS. The chair thanks the gentleman.

Mr. Gaugh, you are recognized for 5 minutes for your opening statement, please.

**STATEMENT OF DAVID R. GAUGH, R.PH.**

Mr. GAUGH. Thank you, Chairman Burgess, Ranking Member Green, and members of the Subcommittee on Health. And first, let me thank you for asking me to participate in this very important and timely hearing. I am David Gaugh, senior vice president for Sciences and Regulatory Affairs at the Association for Accessible Medicines, AAM, formerly GPHA, and I am a licensed pharmacist.

AAM represents key stakeholders to the generic industry and generics represent 89 percent of all prescriptions dispensed in the U.S., but only 27 percent of the expenditures on prescription drugs. As such, generic drugs play an ever-important role in bringing down artificially high prices of drugs, thereby keeping medicines within the reach of the American public.

I would like to begin today by commending the committee for your continued focus on these important issues as we examine them here today. The generic industry's remarkable growth plays a vital role in the lives of Americans every day. This growth in the generic industry has also served to underscore the critically important role of the FDA and, as I will highlight, the level of cooperation between industry and the FDA has never been greater. However, the agency remains underfunded and the responsibility of ensuring access to safe, effective, and affordable medicines is a shared one and that is why the generic industry has agreed to provide FDA with additional resources to address these ongoing challenges.

I am here to discuss AAM's conviction that the best way of achieving the goal of providing patients access to generic alternatives is through the development of policies that promote robust, competitive markets. Generic manufacturers make complex analyses when selecting which products to pursue. This analysis can in-

clude assessing the complexity in reverse engineering, the state of intellectual property of the product, the size of the market, the likely number of competitors, the product development and manufacturing capabilities, and all cost associated. Because of these complexities, AAM believes that the best way to control drug costs generally is through the policies that incentivize competition, and GDUFA II does just that.

The priority of the generic industry in GDUFA II was to achieve a more effective and transparent generic review program. We believe that accomplishing this will improve the rate of first-cycle approvals on the earliest legally eligible date through greater transparency and communications between the agency and the industry. Thus, both FDA and the generic industry benefit by sharing knowledge and experiences throughout the review process. Our goal is not merely a faster review timeline, but a more effective review process. The fewer review cycles required to get to approval, the sooner patients and payers can experience the benefits of generic competition. We strongly believe that GDUFA II is well positioned to achieve this goal.

A few of the key areas to focus on: Application Metrics. So the FDA will act on 90 percent of all ANDAs within 10 months for standard application and all those indicated as priority within 8 months and this includes the inspection component of the review process.

Bridging, or we called it no ANDA left behind—prior to the completion of GDUFA I, all applications and supplements that did not have an official GDUFA I goal date and were subsequently given target action dates will be assigned a GDUFA II goal date on or near October 1 of 2017.

GDUFA II creates a pre-ANDA submission communication pathway for complex products. This early engagement between industry and the FDA will significantly contribute to the applicant's ability to improve the overall submission quality of ANDA's which in turn will contribute to first-cycle approvals.

This agreement includes transparency and communications between FDA and the ANDA applicant through the liberal use of information requests, division review letters, and the complete response letter. These enhancements are intended to decrease the number of review cycles and move them for first-cycle approval.

Reporting and accountability is also included with several new performance and financial reporting requirements to enhance transparency and efficiently maintain them. These new reporting requirements will allow Congress, industry, and FDA to better assess FDA's resource management, planning, and processes.

Small business consideration—the proposal supports small businesses by exempting them from a facility fee until the first ANDA is approved in that facility, and the proposal also provides for the tiering of the annual ANDA program fee based on small, medium, and large companies and this tiering is based on the number of approved ANDAs those companies hold.

In conclusion, Mr. Chairman, the GDUFA II user fee proposal is culmination of months of negotiations between FDA and industry, and the final product as transmitted to Congress represents a careful balance among all stakeholders involved. We respectfully urge

the committee to approve GDUFA II as negotiated and agreed to by the FDA and industry without changes to this agreement. Thank you.

[The prepared statement of Mr. Gaugh follows:]




**Your Generics & Biosimilars Industry**

**TESTIMONY OF DAVID R. GAUGH, R.PH.**

SENIOR VICE PRESIDENT FOR SCIENCES AND REGULATORY AFFAIRS

ASSOCIATION FOR ACCESSIBLE MEDICINES

**EXAMINING FDA'S GENERIC DRUG AND BIOSIMILAR USER FEE PROGRAMS**
HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH

Good morning Chairman Burgess, Ranking Member Green, and Members of the Subcommittee on Health. First, let me thank you for asking me to participate in this timely and important hearing.

I am David Gaugh, Senior Vice President for Sciences and Regulatory Affairs at the Association for Accessible Medicines (AAM), formerly GPhA, and a licensed pharmacist. AAM represents the manufacturers and distributors of finished generic pharmaceuticals, bulk pharmaceutical chemicals, and the suppliers of other goods and services to the generic industry. Generics represent greater than 89% of all prescriptions dispensed in the U.S., but only 27% of expenditures on prescription drugs.

***Introduction***

I would like to begin today by commending the Committee for your continued focus on the important issues we will examine today. As someone who has worked in and around the generic drug industry for more than two decades, I have witnessed firsthand the industry's remarkable growth and the vital role it plays in the lives of Americans every day by providing access to affordable medicines.

This growth in the generic drug industry has also served to underscore the critically important role of the Food and Drug Administration (FDA). As I will highlight, the level of cooperation between industry and the FDA has never been greater, and it is our hope that this collaboration will continue throughout all of our interactions with the agency.

However, the agency remains underfunded, and the responsibility of ensuring access to safe, effective and affordable medicines is a shared one with the entire pharmaceutical industry. That is why the generic industry has stepped up to help provide the FDA with additional user fee resources to address the ongoing challenges caused by an increasingly global drug supply-chain.

***Expedited Generic Access***

I am here to discuss AAM's conviction that the best way of achieving the goal of providing patients access to generic alternatives is through the development of policies that promote robust, competitive markets.

Generic manufacturers make complex and highly confidential analysis when selecting which products to pursue. This analysis can include assessing the complexity in reverse engineering, the state of the intellectual property, the size of the market, the likely number of competitors, the product development and manufacturing capabilities and costs.

Because of these complexities, AAM believes that the best way to control drug costs generally, is through policies that incentivize competition and Generic Drug User Fee Amendment (GDUFA II) does just that.

GDUFA II builds on the experiences – both the successes and shortcomings – of GDUFA I. The priority of the generic drug industry in the GDUFA II negotiations was to

achieve a more effective and transparent generic drug review program. We believe that accomplishing this goal will improve the rate of first-cycle approvals on the earliest legally eligible date through greater transparency and communication during the review process. Greater communication and cooperation between FDA and generic drug sponsors benefits both parties by sharing knowledge and experiences throughout the review process. Our industry's goal was not merely a faster FDA review timeline, but a more effective review process – that enables more approvals during the first-review cycle. Similar to the goals of the branded drug user fee program, PDUFA, reducing multiple FDA review cycles is a critical component of increasing access to affordable generic alternatives. The fewer review cycles required to get to approval, the sooner patients and payors can experience the benefits of generic drug competition. We strongly believe GDUFA II is well positioned to achieve this goal.

**A few key areas of focus in GDUFA II include:**

Application Metrics – FDA will review and act on 90 percent of ANDAs within 10 months after the date of submission for standard applications and 8 months for priority applications. This includes the inspection components of the review process. Priority status will be provided by FDA for submissions affirmatively identified as eligible for expedited review pursuant to current CDER Prioritization Policies (MAPP 5240.3 Rev. 2[1]).

- Submissions containing patent certifications pursuant to 21 CFR 314.94(a)(12);

[1] Center For Drug Evaluation And Research, MaPP 5240.3 Rev. 2 , https://www.fda.gov/downloads/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDER/ManualofPoliciesProcedures/UCM407849.pdf

- Submissions related to drug shortages;
- Submissions that are subject to special review programs such as the President's Emergency Plan for AIDS relief;
- Submissions related to public health emergencies;
- Submissions related to certain government purchasing programs;
- Submissions subject to statutory mandates or other legal requirements;
- Supplements for which expedited review is requested under 21 CFR 314.70(b)(4); and
- Submission for "sole-source" drug products.

Bridging (No ANDA Left Behind) – In GDUFA I, ANDA applications that were filed with the FDA prior to October 1, 2014, did not receive an official GDUFA I Goal Date. However, during early implementation phases of GDUFA I, the FDA agreed to assign Target Actions Dates (TADs) to those applications. These TADs would allow both the FDA and industry to better track the application status. During GDUFA II negotiations, it was agreed that ALL GDUFA I pending applications would be provided an official GDUFA II Goal Date. Therefore, prior to the completion of GDUFA I, all applications and supplements that have been assigned TADs by FDA will be converted to official GDUFA II Goal Dates. For all applications and supplements that were either (a) previously not assigned a TAD or (b) were previously assigned a TAD and the TAD was missed, at the time of GDUFA II commencement, these pending applications will be assigned a goal date by the FDA that shall not be later than July 31, 2018. This will provide for an official accountability for all pending application.

Complex Products – The GDUFA II agreement creates a pre-ANDA submission communication pathway for a subset of generic drug applications, complex products. Like the Breakthrough Therapies program initiated for certain high priority branded drug application, earlier interaction between the applicant and FDA is expected to enhance industry's ability to understand and anticipate FDA's expectations during the critical research and development phase of product development. We also believe that this early engagement between industry and FDA will significantly contribute to the applicant's ability to improve the overall submission quality of ANDA's which in turn will contribute to first-cycle approvals. FDA should consider how it can further enhance communication with generic drug sponsors to improve on its 9% first-cycle approval rate.

ANDA Review Transparency and Communications Enhancements – The agreement includes increased transparency and communication elements between FDA and ANDA applicants throughout the review process through liberal use of Information Requests (IRs) and Division Review Letters (DRLs). These enhancements are intended to decrease the number of review cycles from the 3-4 review cycles experienced today, and move them more towards first-cycle approvals.

Reporting and Accountability – FDA will conduct increased financial and performance reporting to maximize transparency to Congress, industry and the public. The GDUFA II agreement includes several new performance and financial reporting requirements to ensure transparency and efficiencies are maintained. The new reporting requirements

will allow Congress, generic drug sponsors and FDA to better assess FDA's resource management planning and processes to ensure the overall success of the GDUFA program. The quarterly and annual reporting requirements will also provide insight into the financial and performance efficiencies of the FDA, allowing for future program improvements and enhancements.

Small Business Consideration – The GDUFA II agreement supports small business by exempting them from a facility fee until the first ANDA in that facility is approved. The proposal also provides for tiering of the annual ANDA program fees based on small, medium and large companies. This tiering is based on the total number of approved ANDAs for each company.

It is paramount that, as we work to shape the future of our country's generic drug industry, we also work to bring the FDA into the 21st century and ensure that the agency's ability and readiness to achieve its mission in this global age are up-to-date. AAM strongly support the GDUFA II package as negotiated and agreed to with FDA as it provides critical steps in this direction.

By designing GDUFA II to spread fees across multiple stakeholders and sources to keep individual amounts as low as possible, the programs will help assure that patients continue to receive the significant cost savings from generics alternatives. It is important to emphasize that the funding provided by GDUFA II is in addition to, not a substitute for, Congressional appropriations.

***Conclusion***

In conclusion, Mr. Chairman, the GDUFA II user fee proposal is a culmination of months of negotiations between FDA and industry, and the final product as transmitted to Congress represents a careful balance among all the stakeholders involved. We respectfully urge the Committee to approve GDUFA II as negotiated and agreed by FDA and generic drug manufacturers, without any changes to the agreement. It is also vital that the agreement be approved in a timely manner so that patients, the FDA, and generic manufacturers can begin to see the many benefits. Nothing is more important to our industry than ensuring patients have access to the lifesaving generic medications they require, and GDUFA II provides a critical step toward accomplishing this goal. Thank you, and I would be happy to address any questions.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. Ms. Reed, you are recognized for 5 minutes for an opening statement, please.

**STATEMENT OF JULIANA REED**

Ms. REED. Thank you, Mr. Chairman and members of the committee for the opportunity to be here today. I am Juliana Reed, vice president of Government Affairs for Coherus BioSciences and the immediate past president of the Biosimilars Forum. I was a member of the Forum's biosimilars user fee negotiating team last year.

The Biosimilars Forum appreciates the opportunity to testify today regarding its participation in the negotiations for the BsUFA program for fiscal years 2018 to 2022, or BsUFA II, and to provide our perspective on the reauthorization of the user fee legislation. We urge Congress to support the outcome of BsUFA II and to reauthorize the program prior to September 30th, 2017.

The Biosimilars Forum is a nonprofit trade association representing biosimilars manufacturers who are dedicated to the development of a new and sustainable biosimilars market in the U.S. with the goal of expanding access to these important medicines while lowering costs for patients and the overall U.S. healthcare system. The members of the Biosimilars Forum represent the majority of the U.S. biosimilars program and development at the FDA and are subject to the user fees we are discussing today.

The Biosimilars Forum is solely focused on biosimilars and the associated policies necessary to foster a vibrant U.S. biosimilars market that delivers high quality, safe, and effective biosimilar medicines over the long term. This singular focus on biosimilars is important. It is a recognition that biosimilars are unique, they are not generic drugs, and they are not branded biologics.

Biosimilars are a new and distinctive industry sector, created by Congress via the Biologics Price Competition and Innovation Act, or BPCIA, and governed by new and individualized policies and regulations solely devoted to this sector of the biosimilar pharmaceutical industry. In fact, FDA's regulatory treatment of biosimilars reinforces the uniqueness of each product through the agency's approval pathway, naming policy, and pharmacovigilance efforts. This distinction is important to the members of the Forum and something on which we continuously work to educate our partners.

As we work together to build this new industry, we all need to look at biosimilars with a different lens that acknowledges this distinction. The Biosimilars Forum is proud to have participated in industry negotiations with the FDA regarding the reauthorization of BsUFA and greatly appreciates the cooperation of the agency and the other industry groups represented during the negotiations.

The Forum entered into BsUFA II negotiation process with four primary goals: ensuring solid financial support for the program; improving communication between the FDA and biosimilars products sponsors; increasing transparency during the approval process and regarding the spending of user fees; and preventing the expenditure of BsUFA funds on extraneous policy issues or activities that are not exclusive to biosimilars.

Within BsUFA II there are significant enhancements to the biosimilar user fee program that support the review and approval of

biosimilar medicines in the U.S. These agreed-to enhancements include a revised review process meant to increase the transparency and communication that will facilitate an increase in the likelihood of first-cycle approval; agency commitments to complete and publish several draft and final guidance documents that will provide industry with additional clarity and certainty regarding the biosimilar development and review process; agency commitments to augment and strengthen staffing of the biosimilars program including hiring product reviewers; and enhancements to the user fee structure and management that will allow greater transparency, predictability, and long-term stability of the program in the U.S. Again, we encourage Congress to support the BsUFA reauthorization and provide the FDA with the necessary resources it needs to continue to build its program.

Mr. Chairman, reauthorization of the BsUFA is key to successful implementation of the BPCIA. But I would be remiss if I didn't also mention that it is critical for all federal agencies to be consistent in their treatment and support of biosimilars and to recognize that this new industry has additional needs in order to further ensure that biosimilars will increase access and lower costs for patients who need these medicines.

As noted, FDA has a responsibility for making clinical distinctions among products and the agency's policies support the notion that each biosimilar is unique. Unfortunately, CMS did not share this view. Congress should require CMS to review its current reimbursement policy for biosimilars and make it consistent with FDA biosimilar policies. Specifically, FDA policy on biosimilars acknowledges the unique nature of each biosimilar and CMS should align its policy by assigning unique, individualized billing codes to each biosimilar.

FDA guidance to industry makes it clear that each biosimilar is approved in a distinct fashion with variances in approved clinical indications and interchangeability, if possible. FDA's guidance for industry on nonproprietary naming of biologic products further distinguishes individual biosimilars and brand biologics by setting out a naming system whereby different suffixes will be assigned to the name of the biosimilar and its reference products. CMS policy should likewise recognize this distinction for payment and reimbursement purposes.

In addition, as the Biosimilars Forum works closely with patients and the providers who will prescribe biosimilars it is critical that they understand the science behind biosimilars and the FDA's rigorous review process so they have confidence when using and prescribing them. We call on all stakeholders including Congress to support collaboration and education efforts to advance biosimilars.

Thank you for the opportunity to be here. I apologize I went over my time, and I am happy to answer any questions.

[The prepared statement of Ms. Reed follows:]

Biosimilars
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**Testimony of Juliana Reed**
**Vice President, Government Affairs, Coherus BioSciences**
**The Biosimilars Forum**
**Before the House Energy and Commerce Committee Subcommittee on Health**
**March 2, 2017**

Good morning Mr. Chairman and members of the Committee.

Thank you for the opportunity to be here today.

I am Juliana Reed, Vice President of Government Affairs for Coherus BioSciences and the Immediate Past President of the Biosimilars Forum. I was a member of the Forum's Biosimilars User Fee Act (BSUFA) negotiating team last year.

The Biosimilars Forum appreciates the opportunity to testify today regarding its participation in the negotiations for the BsUFA program for FY2018 - FY2022 (BsUFA II) and to provide our perspective on the reauthorization of the user fee program legislation. We urge Congress to support the outcome of BsUFA II negotiations and to reauthorize the program prior to September 30, 2017.

The Biosimilars Forum is a non-profit trade association representing biosimilars manufacturers. We are dedicated to the development of a new and sustainable biosimilars market in the U.S. with the goal of expanding access to these important medicines while lowering costs for patients and the overall U.S. healthcare system. The members of the Biosimilars Forum represent the majority of U.S. biosimilar programs in development at the FDA and are subject to the user fees that we are discussing today.

The Biosimilars Forum is solely focused on biosimilars and the associated policies necessary to foster a vibrant U.S. biosimilars market that delivers high quality, safe, and effective biosimilar medicines over the long-term. This singular focus on biosimilars is important; it is a recognition that biosimilars are unique – they are not generic drugs and they are not branded biologics. Biosimilars are a new and distinctive industry sector, created by Congress via the Biologics Price Competition and Innovation Act (BPCIA), and governed by new and individualized policies and regulations solely devoted to this sector of the bio-pharmaceutical industry. In fact, FDA's regulatory treatment of biosimilars reinforces the uniqueness of each product through the Agency's approval pathway, naming policy, and pharmacovigilance efforts. This distinction is important to the members of the Forum and something on which we continuously work to educate our partners. As we together work to build this new industry, we all need to look at biosimilars with a different lens that acknowledges this distinction.

Biosimilar products are biological products that are approved by the FDA based on demonstrating high similarity to an already-approved biological product, known as a reference product. Biosimilars have no clinically meaningful differences from the reference product in terms of quality, safety and effectiveness. The potential of biosimilars has just begun to be realized, as the first four products were approved over the last two years (with two products currently launched). Biosimilars provide affordable options for patients and contribute to the goal of increasing patient treatment options while providing significant cost savings for the U.S. healthcare system.

**Testimony of Juliana Reed**

The Biosimilars Forum is proud to have participated in industry negotiations with the FDA regarding the reauthorization of BsUFA, and greatly appreciates the cooperation of the Agency and the other industry groups represented during the negotiations.

The Forum entered into the BsUFA II negotiation process with four primary goals:

- Ensuring solid financial support for the program;
- Improving communication between the FDA and biosimilars product sponsors during the approval process to improve efficiency;
- Increasing transparency during the approval process and regarding the spending of user fees; and
- Preventing the expenditure of BsUFA funds on extraneous policy issues or activities that are not exclusive to biosimilars.

We are pleased to say that the resulting agreement expressed in the Commitment Letter and the implementing legislation meet these objectives.

The terms of the Commitment Letter and the reauthorization legislation will provide the necessary time and resources needed by the FDA to support a successful biosimilars program, and meet the Forum's overarching goal of providing ongoing support to this important program. This ultimately will benefit patients by advancing biosimilar approvals and access in the U.S.

Within BsUFA II, there are significant enhancements to the Biosimilar User Fee program that support the review and approval of biosimilar medicines in the U.S. These agreed-to enhancements include:

- A revised review process meant to increase transparency and communication between the FDA and biosimilars sponsors that will facilitate an increase in the likelihood of first-cycle approval;
- Agency commitments to complete and publish several draft and final guidance documents that will provide industry with additional clarity and certainty regarding the biosimilars development and review process;
- Agency commitments to augment and strengthen staffing of the biosimilars program, including hiring product reviewers; and
- Enhancements to the user fee structure and management that will allow greater transparency, predictability and long-term stability of biosimilar development programs in the U.S.

The Forum applauds the efforts made by the FDA to work with industry toward a more efficient and transparent review process. The negotiations resulted in improvements in communication and accountability between sponsors and FDA, and the focusing of the industry's contributions of BsUFA funds on matters exclusively related to the FDA's biosimilars review program. The goals set out in the Commitment Letter and reflected in the reauthorization language will help ensure timely and more transparent review of biosimilar products, to the benefit of patients who need these products.

We encourage Congress to support the BsUFA reauthorization and to provide the FDA with the necessary government resources it needs to continue building its biosimilar program. The commitments made by the FDA, combined with the financial support of Congress and industry ultimately will benefit patients by getting these important products to market.

Mr. Chairman, reauthorization of the BsUFA program is key to the successful implementation of the BPCIA. But I would be remiss if I didn't also mention that it is critical for all federal agencies to be consistent in their treatment and support of biosimilars and to recognize that this new industry has additional needs in order to further ensure that biosimilars will increase access and lower costs for patients who need these medicines. As noted, FDA has responsibility for making clinical distinctions among products and the Agency's policies support the notion that each biosimilar is unique.

Unfortunately, CMS does not share this view. Congress should require CMS to review its current reimbursement policy for biosimilars and make it consistent with FDA biosimilar policies. Specifically, FDA policy on biosimilars acknowledges the unique nature of each biosimilar, and CMS should align its policy by assigning unique, individualized billing codes to each biosimilar. FDA Guidance to Industry makes clear that each biosimilar is approved in a distinct fashion, with variances in approved clinical indications and interchangeability. FDA's Guidance for Industry on Nonproprietary Naming of Biological Products further distinguishes individual biosimilars and brand biologics by setting out a naming system whereby different suffixes will be assigned to the name of the biosimilar and its reference product, in order to differentiate between them in the marketplace. CMS policy should likewise recognize this distinction for payment and reimbursement purposes.

In addition, as the Biosimilars Forum works closely with patients and with the providers who will prescribe biosimilars, it is critical that they understand the science behind biosimilars and FDA's rigorous review process so that they have confidence when using and prescribing them. We call on all stakeholders, including the Congress, to support collaboration and education efforts to advance biosimilars in the U.S.

Thank you for the opportunity to be here today to discuss how to support the development of biosimilars and BSUFA reauthorization.

I am happy to respond to any questions.

Mr. BURGESS. The chair thanks the gentlelady.

Mr. Leicher, you are recognized for 5 minutes for an opening statement, please.

**STATEMENT OF BRUCE A. LEICHER**

Mr. LEICHER. Good morning, Chairman Burgess, Ranking Member Green, and members of the Subcommittee on Health. Thank you for the opportunity to participate in this important hearing. I am Bruce Leicher, Senior Vice President and General Counsel of Momenta Pharmaceuticals and the Chair of the Biosimilars Council Board. I had the opportunity to participate in the BsUFA I as well as the BsUFA II negotiations in those capacities.

The Biosimilars Council is a division of Association for Accessible Medicines. It works to ensure a positive regulatory and policy environment for biosimilar products and educates the public and patients about the safety and effectiveness of biosimilars. We are deeply committed to accessible, affordable, and high quality medicine, and we strongly support the BsUFA III package.

I would like to start with a personal story as someone who has worked in the biotechnology industry for over 25 years and in the biosimilars industry since its inception. About 8 years ago I appeared before the House Judiciary Subcommittee on Courts and Competition Policy to support the BPCIA. Many of the witnesses testified about their fears of biosimilars, how biosimilars were more complicated than generics, and how we should be very careful about proceeding with biosimilars legislation. I testified about how significant scientific innovation would address these concerns and make biosimilar competition possible. I emphasized that American ingenuity would make us global leaders by enacting legislation that did not put a ceiling on biosimilar innovation.

Congress listened and acted with courage. It passed the BPCIA. American innovation was unleashed. Many prior opponents of biosimilar competition entered the business and today we have a growing and thriving biosimilars industry creating good jobs and leading the world with our innovative science, particularly in the science of more fully understanding our biologic products.

Today, Dr. Woodcock reported that over 64 biosimilar programs were under review of development of 23 different biologic products. Momenta alone has seven biosimilar development programs. This was made possible by the BPCIA and by BsUFA I user fee funding. We learned in BsUFA I, however, that the innovation involved in biosimilar development, that is, the science of understanding what is in a biologic for comparison purposes, is complicated and involves many new skills that the industry and the FDA need to understand. This requires new staff and training to assure high quality and efficient review. Historic FDA staffing cannot meet these needs, reviews which depend far less on clinical data and far more on new, innovative scientific techniques that demonstrate that a biosimilar is highly similar to the reference product and has no clinically meaningful differences.

In addition, even more innovation is underway to allow for approval of interchangeable biologics which can be shown to perform the same in any given patient, and, when approved, substituted at the pharmacy like generic drugs. This innovation is what makes

biosimilars competitive, affordable, safe, and effective for patients, but these innovations squarely depend on having the critical additional FDA resources to be funded by BsUFA II.

Innovation was used to craft the BsUFA II commitment letter. We took a hard look at the first 5 years. Not only are new FDA resources needed, more efficient regulatory approaches that use funding more wisely are necessary to accelerate FDA review. Together we included innovations from BsUFA I and PDUFA to enhance the review process and to ensure regulatory clarity. The BsUFA II user fees are now tied to the level of resources needed and adjust with resource demand. It is also important to emphasize that the funding provided by user fees is in addition to, not a substitute for, congressional appropriations, and expenditure is contingent as in the past on an appropriate spending trigger.

Specific improvements include enhanced communication and meeting opportunities that eliminate unnecessary delays; using resource capacity planning to set budgets, staffing levels, and fees; adopting the highly effective program review model to increase first-cycle application approvals; commitments to dedicate staffing and to issue regulatory guidance to promote best practices and predictability; and expanding biosimilar education activities. Each improvement accelerates high quality development and review to help assure that patients have more timely access to lifesaving, affordable, safe, and effective biosimilars.

So in conclusion, BsUFA II is the culmination of months of hard work and negotiations between the FDA and industry. It represents a careful balance among the stakeholders. We respectfully urge the committee to approve a clean draft of BsUFA II without changes to the underlying agreement. Timely passage is important to ensure patients have access to lifesaving biosimilar medications that they require. This historic agreement provides a critical step toward accomplishing this goal.

Thank you, and I would be happy to answer any questions.

[The prepared statement of Mr. Leicher follows:]




**TESTIMONY OF BRUCE A. LEICHER**

SENIOR VICE PRESIDENT AND GENERAL COUNSEL
MOMENTA PHARMACEUTICALS, INC.

BOARD CHAIR, BIOSIMILARS COUNCIL

**EXAMINING FDA'S GENERIC DRUG AND BIOSIMILAR USER FEE PROGRAMS**
HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH

Good morning Chairman Burgess, Ranking Member Green, and Members of the Subcommittee on Health. Thank you for the opportunity to participate in this timely and important hearing.

I am Bruce Leicher, Senior Vice President and General Counsel at Momenta Pharmaceuticals, and Chair of the Biosimilars Council Board of Directors.

The Biosimilars Council, a Division of the Association for Accessible Medicines (AAM), formerly known as GPhA, works to ensure a positive regulatory and policy environment for biosimilar products, and educates the public and patients about the safety and effectiveness of biosimilars. We are deeply committed to accessible, affordable and high quality medicines.[1]

We strongly support the BsUFA II package.

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1 The Council's members aim to provide patients with access to safe, effective alternatives to expensive biologic therapies. Biologic medicines now account for nearly 40% of annual drug approvals by the FDA. Bernard Munos, 2015 New Drug Approvals Hit 66-Year High!, Forbes.com (Jan. 4, 2016), http://www.forbes.com/sites/bernardmunos/2016/01/0 4/2015-new-drug-approvals-hit-66-year-high/#4ecaa3 c11044. With annual U.S. spending on biologic drug therapies exceeding $100 billion, and biosimilars only recently becoming available on the U.S. market, biosimilars offer the potential for tens of billions of dollars in health care savings. And savings are not limited to patients and private insurers; the federal government spends more than $5 billion each year on biologic medicine through Medicaid and Medicare. *See* The Biosimilars Council, The Next Frontier for Improved Access to Medicines: Biosimilars and Interchangeable Biologic Products 14 (2015), available at http://www.biosimilarscouncil. org/pdf/GPhA-biosimilars-handbook.pdf *See also*, Pew Charitable Trusts, Can Biosimilar Drugs Lower Medicare Part B Drug Spending? (Jan. 3, 2017), http://www.pewtrusts. org/en/research-and-analysis/issue-briefs/2017/01/can-biosimilar-drugs-lower-medicare-part-b-drug-spending.

***Introduction***

I would like to start with a personal story, as someone who has worked in the biotechnology industry for over 25 years, and in the biosimilars industry since its inception.

About eight years ago, I appeared before the House Judiciary Subcommittee on Courts and Competition Policy to support the Biologics Price Competition and Innovation Act (BPCIA). Many of the witnesses testified about their fears of biosimilars, how biosimilars were more complicated than generics, and how we should be very careful about proceeding with the biosimilars legislation. I testified about how significant scientific innovation would address these concerns and make biosimilar competition possible. I emphasized that American ingenuity would make us global leaders by enacting legislation that did not put a ceiling on biosimilar innovation.[2]

[2] A key innovation in the BPCIA was the inclusion of the scientific discretion delegated to the FDA to determinate the nature and extent of clinical trials and other development requirements based on its scientific expertise. In implementing the biosimilar regulatory pathway, the FDA adopted a highly innovative approach providing that, to the extent applicants can more fully characterize and understand the structure and function of the reference biologic and the biosimilar, and reduce any differences, clinical trials could be targeted to demonstrating that the differences did not have clinically meaningful differences. This innovation offered biosimilar companies the opportunity to innovate analytical science to reduce development costs and accelerate biosimilar development. The result has been improved understanding of all biologics, and the United States assuming a leadership role in setting standards for biosimilar development. In addition, the inclusion of the interchangeable biologic provisions in the law, made the United States the leader in the development of interchangeable biologics that could, when approved, be substituted at the pharmacy like generics. This created the investment opportunity in the United States to innovate even more and to lead in the development of accessible, affordable biologics. *See* Scientific Considerations in Demonstrating Biosimilarity to a Reference Product (April 2015) https://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM291128.pdf ("Scientific Guidance").

Congress listened and acted with courage. It passed the BPCIA[3]. American ingenuity and innovation were unleashed. Many prior opponents of biosimilar competition entered the business. Today we have a growing and thriving biosimilars industry -- creating good jobs and leading the world with our innovative science –particularly in the science of more fully understanding our biologic products.

In October, the FDA reported that over 66 biosimilar programs were under review for development of 20 different biologic products.[4] Momenta alone has seven biosimilar development programs.[5]

This was made possible by the BPCIA, and by BsUFA I user fee funding. We learned in BsUFA I, however, that the innovation involved in biosimilar development – the science of understanding what is in a biologic for comparison purposes – is complicated and involves many new skills that the industry and the FDA need to understand. This requires new staff and training to assure high quality and efficient review. Historic FDA staffing cannot meet these needs which depend far less on clinical data, and far more on new innovative scientific techniques that demonstrate that a biosimilar is highly similar to the reference product and has no clinically meaningful differences.[6] In addition, even more innovation is underway to allow for approval

[3] Pub. L. No. 111-148, Tit. VII, Subtit. A, 124 Stat. 119 (2010).

[4] This data was shared in the presentation presented by FDA to Congressional Staff on BsUFA II in October 2016. More programs that will be reviewed during BsUFA II are likely in development but because they have not reached the FDA stage of review, are not included in these statistics.

[5] For example, Momenta Pharmaceuticals nearly doubled its employment as a result of entering the biosimilars business.

[6] *See* the discussion of the stepwise development process in the Scientific Guidance, referenced in note 2, *supra*.

of interchangeable biologics which can be shown to perform the same in any given patient and, when approved, substituted at the pharmacy like generic drugs. This innovation is what makes biosimilars competitive, affordable, safe and effective for patients.[7] But, these innovations squarely depend on having the critical additional FDA resources funded by BsUFA II.

Innovation was used to craft the BsUFA II Commitment Letter. We took a hard look at the first five years. Not only are new FDA resources needed, more efficient regulatory approaches that use funding more wisely are necessary to accelerate FDA review. Together we included innovations from BsUFA I and PDUFA to enhance the review process and to ensure regulatory clarity. The BsUFA II user fees are now tied to the level of resources needed and adjust with resource demand. It is also important to emphasize that the funding provided by user fees is in addition to, not a substitute for, Congressional appropriations. Expenditure is contingent, as in the past, on a spending trigger tied to Congressional appropriations.

Specifically these include[8]:

- Enhanced communication and meeting opportunities that eliminate unnecessary delays in development and review[9]

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[7] Substitution at the pharmacy is a key factor in making biologics affordable. Like generic drugs, interchangeable biologics will not require the same level of marketing in order to promote use allowing for even greater competition.

[8] Other key improvements in the BsUFA II Commitment letter include the additional or written guidance for BPD Type 2 meetings to avoid unnecessary meetings and reduce the time for scientific feedback, the adoption of the 4 month review of manufacturing prior approval supplements to facilitate manufacturing expansion, and the inclusion of third party evaluation of the Program to facilitate further improvement based on objective feedback.

[9] The meeting deadlines were adjusted based on BsUFA I experience to allow for the most effective use of the meetings to accelerate program development. Initial Advisory meeting were accelerated, and Type 2 meetings were extended to allow the Agency to have the time to provide complete answers and better guidance. At the same time an option for written advice was added which could accelerate in many situations the time to receipt of Type 2 meeting advice.

- Using resource capacity planning to set budgets, staffing levels and fees[10]
- Adopting the highly effective Program Review Model to increase first cycle application approvals; and training of review teams for greater effectiveness[11]
- Commitments to dedicate staffing and to issue regulatory guidance to promote best practices and predictability
- Expanding biosimilar public education activities

Each improvement accelerates high quality development and review to help assure that patients have more timely access to life-saving, affordable, safe, and effective biosimilars.

***Conclusion***

In conclusion, BsUFA II is the culmination of months of hard work and negotiations between FDA and industry. It represents a careful balance among the stakeholders. We respectfully urge the Committee to approve a clean draft of BsUFA II, without any changes to the underlying agreement. Timely passage is important to ensure patients have *access* to the lifesaving biosimilar medications they require. This historic agreement provides a critical step toward accomplishing this goal. Thank you, and I would be happy to address any questions.

[10] The use of capacity resource measurement and planning will help ensure that the level of funding is actually tied to the resources needed and will allow for adjustment of fees up and down as the number of programs fluctuate. This should make the review more efficient, avoid the opportunity cost of delays, and allow for adjustment of fee allocation to the kinds or resources actually needed by the Agency. For example, as the number of marketed products increase, the fees will increase and fees may be reduced on the pre-application development side.

[11] The Program Review Model was tested in PDUFA and puts in place performance obligations, communication commitments, pre-filing meetings, mid-cycle communication and a late cycle meeting. Experience shows that the enhanced communication conserves FDA resources and applicant resources and has enabled first cycle approval more often that when it was not in place. This should accelerate approval of high quality applications.

Mr. BURGESS. The chair thanks the gentleman. Ms. Holcombe, you are recognized 5 minutes for an opening statement, please.

**STATEMENT OF KAY HOLCOMBE**

Ms. HOLCOMBE. Mr. Chairman, what an honor it is to speak with you today. In 1992, this committee planted the seed that has grown into user fee programs that provide FDA with a significant portion of the resources it needs to ensure that patients have timely access to safe and effective medicines. This committee also successfully produced with an overwhelming bipartisan House vote, the BPCIA, legislation that established an FDA pathway for the approval of biosimilars.

BIO was an early and strong supporter of this legislation to create a balanced pathway for greater competition in the biologics marketplace and of the user fees to make that work. BIO is the world's largest trade association representing biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than 30 other nations. Our membership includes most of the large biopharmaceutical companies, but the vast majority of our members are small biotechnology companies working on the most cutting-edge R&D. BIO is proud of the innovative spirit and dedication of these small companies.

I want to focus my comments today principally on the reauthorization of the biosimilars user fee program. We believe the BsUFA reauthorization proposal you are considering meets all of our overarching goals and supports and enhances the biosimilars user fee program. We strongly support timely reauthorization of BsUFA.

During the course of BsUFA I, FDA issued guidance documents to assist sponsors and other stakeholders to understand the agency's expectations and how this new process would work. They also issued final guidance on naming for biosimilar and innovative biological products to establish a way to provide clarity for prescribers and patients and to assist pharmacovigilance. In addition, FDA issued five guidance documents that remain in draft, including the most recent draft guidance on the agency's views on determining interchangeability.

BIO continues to urge that the agency finalize this draft guidance as quickly as possible as interchangeability is an important component of promoting the biosimilars marketplace. Because of both the complexity of the products and the novelty of this category of highly similar or interchangeable products, we recognize that these early years necessarily have been a time of learning and building. And although four new biosimilars products approved since enactment of BPCIA and initiation of BsUFA may seem like a small number, we are confident that the program and the availability of biosimilars to patients will grow as the agency builds expertise and capacity.

With this as background, BIO worked with FDA, other industry organizations, and other stakeholders to develop proposals for continued progress and enhancements during BsUFA II. Some of the key commitments have already been mentioned here and I am not going to mention them again. The hope is that these new programs

under BsUFA II will enhance the ability of sponsors and patients to work together to get biosimilars to the marketplace.

I want to mention in particular the BsUFA commitments that relate to financial enhancements of the program to provide sustainability for the BsUFA program and to provide commitments to hiring goals and moving forward with FDA's hiring of the skilled staff that it needs to do its job. BIO has longstanding views about the negative potential consequences of the sequester of user funds or hiring freezes that can result in FDA's inability to fill vacancies and make the new hires that are necessary for meeting its commitments under these user fee programs.

User fees support a significant number of FDA personnel including those needed to carry out the BsUFA commitments. If FDA is unable to make these hires, user fees cannot be spent. This is a situation that is unacceptable to fee payers and is not good for FDA or for the patients who are waiting for the approval of biosimilar therapies.

Finally, Mr. Chairman, I want to address very briefly your request to comment on the Lower Cost Drugs Through Competition Act. BIO supports competition in the prescription drug marketplace. We believe a robust, competitive market exists today, but we also recognize that there can be more done to promote generic entry particularly where an older, off-patent drug has lost regulatory exclusivity yet lacks meaningful generic competition.

We all want to see FDA approve generic drugs as efficiently as possible. Competition and greater choice are good for patients, and whatever reasonable steps can be taken to help FDA enhance its generic drug processes should be considered seriously. On behalf of BIO, I want to thank you for the opportunity to present our views today, and I am happy to take any questions you may have.

[The prepared statement of Ms. Holcombe follows:]

**Testimony of Kay Holcombe, Senior Vice president, Science Policy,**

**Biotechnology Innovation Organization**

**United States House of Representatives**

**Energy and Commerce Committee, Subcommittee on Health**

**Hearing on "Examining FDA's Generic Drug and Biosimilar User Fee Programs"**

Mr. Chairman, Ranking Member Green, and Members of the Subcommittee,

What an honor it is to speak to you today on behalf of the Biotechnology Innovation Organization (BIO) about the Biosimilars User Fee Act reauthorization. This Committee planted the seed that has grown into multiple user fee programs that provide FDA with a significant portion of the resources it needs to ensure that patients have timely access to safe and effective new drugs and biologics, generic drugs, biosimilars, and medical devices. This Committee also tilled the ground and successfully produced, with an overwhelming bipartisan House vote, the legislation that established an FDA pathway for the approval of biosimilars – the Biologics Price Competition and Innovation Act (BPCIA). BIO was an early and strong supporter of this legislation to create a facilitated and balanced pathway for greater competition in the biologics marketplace.

I am Kay Holcombe, the Senior Vice President for Science Policy at BIO. BIO is the world's largest trade association representing biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than 30 other nations. While our membership includes most of the large biopharmaceutical companies, the vast majority of our members are small biotechnology companies working on the most cutting-edge R&D. They have small staffs, no marketed products, and no profits, and they are heavily reliant on private capital to fund their work. They take enormous risks every day to develop the next generation of biomedical breakthroughs for the millions of patients suffering from diseases for which there are no effective cures or treatments today. BIO is proud of their innovative spirit and their dedication to alleviating human suffering.

You asked for our views on two proposals the Committee is considering: the Biosimilars User Fee Act and H.R. 749, the Lower Drug Costs through Competition Act. In summary, BIO strongly supports the reauthorization of BsUFA, as we supported the initial enactment of the BPCIA and the initial BsUFA program. We also want to express support for competition in the prescription drug marketplace not only between innovator biologics and biosimilars, but also between innovator drugs and generic drugs – which is the subject of H.R. 749. We believe that, in both cases, our shared ultimate goal is achieved – to provide patients with greater access to therapies that save and improve their lives.

As BIO's lead negotiator for the BsUFA process, I want to focus my comments today principally on this reauthorization. As BIO considered this approaching reauthorization in consultation with our members and other stakeholders, we coalesced around two over-arching goals. First, we want to ensure that FDA will have the resources over the next five years of the BsUFA program to accomplish the fundamental objectives of the program, including clarifying further and enhancing the processes and tools the agency uses to regulate biosimilars. Second, we want to improve the transparency, financial accountability, and sustainability of the BsUFA program. We believe the BsUFA reauthorization proposal meets these two goals.

**What Has Been Accomplished during BsUFA I?**

To inform our thinking, we looked at what FDA has accomplished in the first four years of the program, including reviewing the third-party assessment of the costs and workload associated with activities related to the development of policies and procedures to implement the new biosimilars program and to the review of biosimilar applications.

FDA has issued five final Guidance documents to assist sponsors and other stakeholders to understand some of the agency's thinking about how the new biosimilars pathway would work and about its expectations regarding the kinds of studies and data that would be required for biosimilars approval. FDA also issued final Guidance on naming for biosimilars and innovator biological products. This was a particularly important document that needed to take an approach that would provide clarity for prescribers and patients and assist pharmacovigilance, but not suggest, by virtue of a naming convention, that some products may raise safety or efficacy issues that do not exist.

FDA also has issued an additional five Guidance documents that remain in draft, including the recent draft Guidance regarding FDA's views on determining interchangeability. BIO has urged FDA to lay out its thinking on interchangeability, so we are pleased that a draft is available for public comment. We hope the agency will finalize this draft as quickly as possible after the public comment period ends. Many stakeholders believe it is crucial for FDA to explicate its expectations for the data needed to determine that a biosimilar product is interchangeable with its reference biological product, which the statute defines as a biosimilar that can be substituted for, or switched with, the reference product with no adverse impact on any given patient's clinical outcome. Such a determination, many believe, may serve to encourage greater prescribing and use of biosimilars as the availability of biosimilar products increases, provided the determination is sufficiently rigorous.

Beyond issuing these Guidance documents, FDA has committed substantial time and resources to make the pathway to approval for biosimilars viable and credible. Because of both the complexity of the products and the novelty of this category of "highly similar" or "interchangeable" products, we recognize that these early years necessarily have been a time of learning and building within the agency. And although four new biosimilars approved since enactment of the BPCIA and the initiation of BsUFA

may seem like a small number, we are confident that the program – and the availability of biosimilars – will grow as the agency builds expertise and capacity.

In fact, as FDA has reported in its annual BsUFA Performance reports and as an independent contractor also has documented, the number of meetings between FDA and sponsors planning or executing biosimilars development programs has increased substantially since the program began. As of October 2016, based on meetings between FDA and sponsors, there are 66 biosimilar development programs under way, to develop biosimilars to 20 different reference biological products. Of course we do not know what percentage of those programs will result in applications, or which applications will be approved. But the numbers certainly demonstrate the upward trend for which supporters of biosimilars have hoped.

**What Can Be Accomplished during BsUFA II?**

BIO worked with FDA and other industry organizations representing biosimilars developers and innovators, with input from many other stakeholders such as patient organizations and healthcare providers, to develop detailed proposals for continued progress and enhancements during BsUFA II. These proposals are encapsulated both in the legislative language proposed to this Committee and in the Biosimilar Biological Product Authorization Performance Goals and Procedures for Fiscal Years 2018 through 2022, referred to as the Goals Letter. The Goals Letter is of particular interest because it defines the commitments FDA is able to make as a result of receiving the Congressionally-authorized BsUFA fees. Among those commitments are several I want to highlight.

Review Timelines

First, FDA agrees to meet defined timelines for its reviews and decisions regarding biosimilars applications. Specifically, for 90% of original applications, a decision will be made within 10 months of the date on which the application is officially accepted for review by the agency. How well FDA does in meeting this timeframe, like others for re-submitted applications and supplements, will be reported annually and publicly by the agency.

Meeting Management

FDA-sponsor meetings before an application is submitted have been a key part of BsUFA and an essential component of a concerted effort to stand up this new program. These are formal opportunities for sponsors to discuss their development plans and approaches with the agency reviewers and receive technical assistance regarding ways to proceed that will give the development program the highest chance of success. Under BsUFA I, there was agreement that user fees would be associated with these meetings; that agreement will continue under BsUFA II. It is a long-term goal we share with FDA that these Biosimilar Product Development meeting fees eventually will be phased out, based on the agency's ability to meet its annual target revenue for the BsUFA program, and to meet its performance goals with fees assessed on biosimilars applications and products – as is the case, for

example, in the PDUFA program. This will require a more significant increase in applications and products than is expected over the next five years.

Some enhancements to the formal meeting processes also are among the performance goals for BsUFA II. These have the purpose of ensuring that requirements for both FDA and sponsors, in terms of response times, meeting times, and documentation, are reasonable to allow for the best and most productive meetings and the most timely and useful advice for sponsors.

New Review Program

A new approach to the review of biosimilars applications will be implemented during BsUFA II, which is modeled after the so-called "new NME" program under PDUFA. The anticipated advantage of this program is an increase in the number of first-cycle approvals – saving time and money for sponsors and, importantly, making approved products available to patients as efficiently as possible. The Program provides applicants with new opportunities, during the course of the review, to receive updates from FDA about how the review is proceeding. If there are questions or concerns, the applicant will have a chance and the time to respond – avoiding a scenario of last-minute problems that cannot be resolved adequately in the time remaining before the BsUFA deadline.

Based on an independent third-party review of the PDUFA "new NME" program, the program has been highly successful in the view of both the FDA and sponsors. Importantly, this approach has achieved its intent to increase the number of first-cycle approvals. In short, this means there is a higher chance that an application entering FDA in month one will exit, approved, in month 12. In addition, this approach greatly reduces the chance that the 12-month timeline will be extended, or that the application will need to be submitted for a second review cycle, thus delaying its approval and availability to patients for as long as another full review cycle.

The hope, in establishing this type of program under BsUFA II, is that results will mirror those that have been seen for new drug and new biological license applications. In other words, more and more productive communication between FDA and sponsors will lead to less overall time to product approval.

Under the program, the applicant is encouraged to meet with the FDA review team to discuss the content of the planned application in advance of the submission. Once the complete application (as agreed at the pre-submission meeting) is accepted for review by the agency (60 days), the 10-month count-down begins. At approximately mid-cycle, FDA will arrange a mid-cycle meeting with the applicant – in most cases by telephone – during which appropriate review team members will update the status of the application and identify any concerns or questions, discuss the review team's thinking about possible post-market requirements, and provide the applicant with upcoming milestone dates such as advisory committee meetings. If an advisory committee is planned, it will be scheduled at least two months before the end of the 10-month review time.

A second, late-cycle meeting will be held no later than 12 days before any planned advisory committee meeting. At this meeting – usually a face-to-face meeting – FDA will discuss with the applicant any major deficiencies in the application, the agency's views on the submitted data and any additional data

that may be needed, manufacturing issues, inspectional findings, any proposed post-market requirements, and any issues FDA plans to raise with the advisory committee. This timeframe will provide the applicant more than two months before the BsUFA goal date to work with FDA to resolve outstanding issues – a meaningfully longer time than frequently was the case previously. And if there is no advisory committee planned, the late-cycle meeting will occur no later than three months before the BsUFA goal date.

The establishment of this new review approach is significant for several reasons. First, it provides clear, guaranteed, important opportunities for applicants to know what is happening with their reviews – in a timely way that allows them to have meaningful input and an opportunity to address problems and concerns. Second, it provides timeframes for various steps in the review process that are publicly reportable through FDA's BsUFA annual Performance Reports. While we are hopeful that this type of program will be as relevant and helpful as it has been in the innovator context, it is critical that, given the inherent differences in the biosimilars development and approval processes, an independent third-party evaluation of this new biosimilars review program be undertaken. Under the Goals Letter, the evaluator will look not only at how the program is working and whether it is achieving its aim of more first-cycle approvals, but also at the question of whether and to what extent the earlier Biosimilar Product Development meetings, for which applicants also pay user fees, could have or should have identified issues that subsequently may be raised at a mid-cycle or late-cycle meeting during the review. Under the Goals Letter, the third-party evaluator will submit both an interim and a final assessment of the program, by the end of 2020 and by June 2022 respectively. These reports will be published for public comment, and public meetings will be held on each.

Guidance

Stakeholders across the spectrum agree that timely and substantive guidance, particularly in this new program area and for this new approval pathway, is essential to the success of the program. The lack of Guidance leads to uncertainty and missteps that limit or delay the availability of new safe and effective products for patients. Guidance that remains in draft for lengthy periods of time has the same effect. Thus, it is important that goals be set under BsUFA II not only for the issuance of new Guidance that explains FDA's perspectives in general, as well as with respect to specific biosimilars products or types of products, but also for the finalization of Guidance already issued in draft. Those goals are laid out clearly in the Goals Letter. While meeting these goals – a key publicly reportable user fee commitment – FDA also needs to ensure that the public has ample opportunity to comment on draft Guidance and that such public comment is taken into account in the finalization of any Guidance.

In addition, the Goals Letter provides FDA's commitment to revise and update the Good Review Management Practices Guidance and general guidance relating to processes, procedures, and timelines for meetings between FDA and sponsors, both of which apply to NDAs and BLAs, to include and reference biosimilars specifically.

Finally, the Goals Letter includes FDA's commitment to continuing to clarify the biosimilars review pathway and provide information important to sponsors both of biosimilars and innovator biological

products. This includes, for example, revision or re-issuance of Guidance relating to the so-called "transition" products; harmonization of varying definitions of "biological product;" and updating of the "Purple Book" with information including the date of first licensure of potential reference biological products.

Financial Transparency and Accountability and Program Viability through Enhanced Resource Management, Capacity Planning, and Time Reporting

BsUFA will benefit from the modernized time reporting and new capacity planning efforts being undertaken across the Centers for Biologics (CBER) and Drugs (CDER). By statute, FDA staff who review biosimilars applications are the same as those who review applications for approval of new drugs and new biological products. Therefore, modernized time reporting will be as useful for determining resource needs for BsUFA as for PDUFA. Modernized time reporting will provide data that are much more accurate than currently available about the time and resources actually spent and required to complete the various tasks associated with application review. Having this information will allow FDA, for both the BsUFA and the PDUFA programs, to plan in advance for the capacity necessary to meet the needs of future years. By the second quarter of 2018, FDA will publish an implementation plan for establishing and utilizing a capacity planning function and modernized time reporting, which will include biosimilars review activities specifically.

Further, an independent third party will evaluate various options and make recommendations regarding the best ways for FDA to assess its resource needs on an ongoing and forward-looking basis, for all CDER and CBER review-related activities. The specific tasks associated with the review of biosimilars applications will be built into this assessment. As with all other BsUFA and PDUFA reports and assessments by FDA or by independent contractors, this evaluation will be public, and public comment will be invited and taken into account.

These activities are critically important to those who pay user fees. They assure that fee payers and other stakeholders can be confident that there is a sound basis on which target revenues and fee amounts are calculated. It has been especially difficult to predict the amount of funding needed for BsUFA, because this is a new-to-the-U.S. industry without a history of development times or application submissions. This will change with time, but until then, the perspectives of experienced independent experts will be essential.

FDA also will include BsUFA resource management in the scope of work for the contractor that will evaluate PDUFA resource management. This evaluation will include an assessment of how the BsUFA program is administered, how the user fee funds are allocated and used, and what changes might be made to improve the governance of the program.

FDA will publish a five-year financial plan by the second quarter of 2018 and update the plan annually. The plan and updates will be made public, and FDA will convene annual public meetings to take comments on the plan and on how FDA is executing it.

Hiring

As this Committee is very aware, FDA has had significant problems hiring the experts it needs to do its work. This matter was discussed in depth during the development of the BsUFA reauthorization proposals, as it was during PDUFA discussions. In both contexts, FDA committed to making changes internally to makes its processes better.

BIO, as part of the FDA-regulated industry, supports a strong, capable, and skilled FDA that can make timely and science-based decisions in the interest of patients and the public health. Achieving this hinges on the agency's ability to attract, hire, and retain highly educated scientists, physicians, statisticians, and others. We are especially appreciative of this Committee's efforts, working with the Senate HELP Committee and many other Members of the House and Senate, to include changes in the 21st Century Cures Act that will greatly benefit FDA's hiring capabilities. These changes will provide FDA with some key authorities that it needs to attract the highly educated, experienced, and talented individuals we all want to see working on our applications for approval.

But FDA itself needs to improve, and that process is under way already. Numerous changes have been made and more are expected. Both the BsUFA II and the PDUFA VI agreements include a commitment that FDA will contract with third parties to help implement its new and expedited Human Resources processes and to evaluate on an ongoing basis the progress the agency is making. Because all the reviewers in the BsUFA program also are PDUFA reviewers, it is crucially important to the success of the biosimilars program for FDA to meet the significant hiring goals under PDUFA. Even more important is for the agency to put in place sustainable and durable processes and procedures, so that this hiring is not merely a five-year surge, but is a lasting approach that keeps FDA staffed at the level it requires to do its job.

Importantly, all of the activities that will be and already are being undertaken to improve the hiring situation will be public. We all will be able to see the assessment of the third-party evaluator, consider any recommendations, and provide comments to FDA. We also will be able to see the numbers. We do not want FDA to fall behind its hiring goals, because we know that the user fee commitments we rely on cannot be met unless the people are there to meet them. Annual hiring goals are included in the BsUFA and PDUFA agreements, and the public will be able to see in the annual Performance Reports whether these goals are being met. We want to see what is happening so we can work with this Committee and FDA to help stop any downward trend. We believe we share this goal with stakeholders across the spectrum. And we know, because of what this Committee did in 21st Century Cures, that we share it with all of you as well.

In discussing FDA hiring, I also want to reiterate BIO's longstanding views on the potential negative consequences that arise from the sequester of agency funds or hiring freezes that can result in FDA's inability to fill vacancies and make new hires that are necessary for meeting its commitments under the prescription drug and biosimilars user fee programs – or, in general, for carrying out its crucial public health responsibilities. User fees paid by biosimilars applicants, as well as user fees paid by applicants for new drug and new biological product approvals, support a significant number of FDA personnel. In

particular, they support the staff identified to carry out the program performance goals. If FDA is unable to make these hires, user fees cannot be spent. This is a situation that is not good for fee payers, for FDA, or for patients who are waiting for approved therapies.

**H.R. 749: The Lower Drug Costs through Competition Act**

Before I conclude, I will briefly address the second topic of this hearing, the Lower Drug Costs through Competition Act.

BIO supports competition in the prescription drug marketplace. Indeed, the United States has a robustly competitive market for drugs, where innovators compete vigorously with one another to produce safer and more effective medicines within the same class, and then compete on price as part of negotiations with powerful, sophisticated, and aggressive commercial middlemen such as insurance companies and pharmacy benefit managers who control patient access to these innovative products. While there are pockets of exceptions to this competitive environment, the reality is that the average innovator drug has a short period of time on the market without competition from other similar products, and roughly 90% of all prescriptions filled in America are for cheaper generic copies of once-branded drugs.

Still, BIO recognizes that more can be done to promote generic entry, particularly where an older, off-patent drug has lost regulatory exclusivity yet nonetheless lacks meaningful competition for various reasons. We all want to see FDA approve generic drugs as efficiently as possible and for the backlog of generic drug applications to be reduced quickly.[1] Unwarranted delay in access to such medicines is not good for patients. More choice and competition is good for patients, and whatever reasonable steps can be taken to help FDA enhance its generic drug processes should be considered seriously.

BIO does not have a position on the question of timelines for generic drug review or awarding certain generic drug applicants with priority review vouchers, as H.R. 749 contemplates. We defer to the Association for Accessible Medicines, which represents generic drug manufacturers, for analysis of those provisions. However, BIO does support as a matter of policy efforts to lower drug prices through the promotion of more robust competition in the drug marketplace, including the timely entry of generics and biosimilars once patents and exclusivities for innovator drugs have expired.

Thank you for the opportunity to testify today on behalf of BIO. I am happy to answer any questions you may have.

[1] We note that there have been numerous statements in the press about an unacceptable number of drugs in an FDA backlog. The number 4,000 has been mentioned. In some cases, there has been an implication that innovator drugs and biologics may be in this large backlog. That is not the case. In fact, for new drugs and biologics, FDA is meeting its performance goals under PDUFA. This large backlog is of generic drugs.

Mr. BURGESS. The chair thanks you. That concludes our witness testimony. We will move into the question portion of the hearing for our second panel. I recognize myself 5 minutes for questions.

Mr. Gaugh, if I could start and ask you, you were here, I think, when Dr. Woodcock gave her testimony. And I think, if I understood her correctly, she said that there is no backlog in the approval of generic drugs, and I would just ask you if you agree with that statement.

Mr. GAUGH. So there is a bit of a discrepancy between the industry and the FDA on that statement, whether or not there is a backlog, but it doesn't really matter what word you use. I do agree with Dr. Woodcock that all applications are currently under review. But if you look back at the original statutory backlog of GDUFA I, there were 2,866 products in that category. There are now 1,500 in that category that are still not approved. So they are going back and forth under active review between the FDA and industry, but those are still sitting there so they have been there for 4 years or longer. Add in year 1 and year 2 applications and there is another 2,000, roughly, and those have been under review for at least 2 years.

Mr. BURGESS. Mr. Gaugh, staying with you, I guess the question is has the FDA met all of its goals under the first generic drug user fee agreement?

Mr. GAUGH. Yes, they have.

Mr. BURGESS. But then we continue to hear significant concern about review times and the number of cycles it takes to approve applications, the lack of communication between review division staff and applicants, so are you confident that the new agreements will address those concerns?

Mr. GAUGH. Yes. So in the first agreement, in GDUFA I, there were no solid metrics—I will use that phraseology—for the pre-GDUFA and years 1 and years 2. In years 3, 4, and 5 there were solid metrics. So we have seen some significant advances in those years and that is why we are asking the FDA to divide out the metrics, or the report-out metrics if you would that they are giving us, in cohort years, so we can know how things are happening per year.

When we look at a first-cycle review of only nine percent that is looking over the entire cohort. We would like to see what that looks like per cohort.

Mr. BURGESS. I guess what I would like to get from you is a sense as what the FDA can do to substantially improve the review process and what steps can industry then take to improve the quality of submissions on a more consistent basis?

Mr. GAUGH. So the steps we have taken in GDUFA II are a couple. One, Dr. Woodcock talked about the complex products, and so we have preapplication meetings that help us understand that. That happens with every one of the products under the ANDA, understanding there is only about 150 to 175 products there, but they have that opportunity to have those conversations before the application is even submitted, so both industry and the FDA knows what is coming in the door.

Under GDUFA II we have done that in the complex products and so we think that will take large steps in getting to that first-cycle

review for complex. It doesn't fall for the noncomplex products. But remember, there is over a thousand applications that are entered into the FDA every year for review and approval. That would be a huge resource drain to try to have those pre-meetings. We are working in that direction, but again this is GDUFA II, not GDUFA VI.

Mr. BURGESS. And thank you. I thank you for your responses.

Ms. Holcombe, if I could ask you, you referenced in your testimony the learning and building that has been going on during the Biosimilar User Fee Agreement course. If I understand correctly there have been four approvals with biosimilars; is that accurate?

Ms. HOLCOMBE. Yes, that is accurate.

Mr. BURGESS. It seems like a low number.

Ms. HOLCOMBE. It does.

Mr. BURGESS. So would you care to expound upon that?

Ms. HOLCOMBE. We have hope.

Mr. BURGESS. We all have hope.

Ms. HOLCOMBE. I know hope is not a strategy.

Mr. BURGESS. This is a very hopeful subcommittee.

Ms. HOLCOMBE. As Dr. Woodcock mentioned, FDA is working with sponsors, biosimilar sponsors, now through the course of the biosimilar product development meetings on 64 development programs to 23 reference biological products. So we can't obviously predict that all 64 of these are going to turn out to have marketed products, but certainly some high percentage of them will. So we could move over the next few years, certainly over the next 5 years, from 4 products to 56, let's say, or even 46, which would be terrific.

Mr. BURGESS. Agreed. That would be terrific.

I yield back my time and recognize Mr. Green for 5 minutes for questions, please.

Mr. GREEN. Thank you, Mr. Chairman.

And Mr. Leicher, in the first panel Dr. Woodcock discussed the increasing number of meeting requests that the agency received from sponsors. You mentioned in your testimony that one of the improvements under BsUFA II is enhanced communication and meeting opportunities that are hopefully help to eliminating delays in development and review of biosimilars.

My first question, what improvements to these meetings with sponsors would be made under BsUFA II and why are these improvements helpful from your perspective?

Mr. LEICHER. So yes, there are several improvements that have been made. One was a discussion that we had with the agency about including specific reference to biosimilars in the preapplication IND best practice guidance document as well as in the meeting guidance documents which provide for specific responses, commitments to time frames for responses, and that can really enhance sort of correcting things in advance before an application is filed.

The other piece is the adoption of the program review model which was developed in PDUFA, so that when an application is filed there are specific goals set within the agency for timelines. There is a preapplication meeting with the sponsor to work out complicated issues and make sure that what is filed is approvable. And there is a series of communications and responses to the appli-

cants so that you can actually strive for a first-cycle review the first time and do it right the first time.

Mr. GREEN. BsUFA II also moves from a 10-month timeline for review to a 12-month. Can you explain why this change was made and how will this impact the biosimilars?

Mr. LEICHER. The ultimate goal of the change was to get to first-cycle approvals. What we believe was learned in PDUFA was that additional time was important to enable the communication that I was just discussing to occur so that we can actually respond to information requests and to communications in that time frame and actually finish it the first time, rather than have it coming back and then waiting another 6 months beyond the 10-month period.

Mr. GREEN. And our goal again is to move with the process to make sure they do their job but also move it quickly. Mr. Coukell, the FDA approval process ensures drugs are safe and effective. Some have proposed policies to address pricing that circumvents that process. Do you have a position on whether we should look for solutions to pricing concerns that go outside the FDA approval process?

Mr. COUKELL. Thank you for that question. Dr. Woodcock in her testimony talked about the FDA's process for going out to a manufacturing facility and being on the floor and really seeing what happens there, and then talked about looking at data on bioequivalence to make sure that the copy of the innovative product performs in exactly the same way. If we are getting drugs that haven't gone through that process we don't have those same guarantees.

Mr. GREEN. Thank you. This is a question for both of you and Mr. Gaugh. I think we all agree that generic drugs are saving money and making medicines more affordable to patients. In fact, the Association for Accessible Medicines estimates that the generics are saving American families over $4 billion a week. And while generics account for 89 percent of the prescriptions expenses in America, it is only 27 percent of the total drug cost. That is why I think it is important to do what we can to reduce the barriers to the generic competition and lower the often burdensome cost of prescription drugs.

Mr. Schrader and Mr. Bilirakis have proposed one way to address this important issue, and I am interested to hear what else could be done to increase generic competition in the market. Mr. Gaugh, what other policy proposal do you believe should increase generic competition and access to generic drugs, and also to Mr. Coukell and Mr. Gaugh.

Mr. GAUGH. Thank you. Dr. Woodcock also spoke earlier today about the REMS situation that we have. And so I know that in that bill that Representative Bilirakis and Schrader put forward that was to have a study on REMS, but we don't need another study on REMS. We have been looking at REMS since I was at the GDUFA table in 2012 and working on solutions for that. And we have had solutions that have been presented even in the last 6 months that never quite make it into the bill.

So REMS is one of the main indicators that prevents generic products from coming to market because we can't get the product to be able to develop it and develop the generic of the innovator.

Mr. GREEN. Mr. Coukell, do you want to use my last 19 seconds?

Mr. COUKELL. Well, there aren't that many drugs with that type of REMS, but there are some big drugs in there. One of them in that category is the seventh-most costly drug in the Medicare program. It is $2 billion a year. So making sure that there is a pathway to market for generic versions of those drugs and non-REMS drugs that have restricted distribution could be meaningful.

Mr. GREEN. OK. Thank you, Mr. Chairman. I yield back.

Mr. LANCE [PRESIDING]. Thank you very much. The chair recognizes Dr. Carter of Georgia.

Mr. CARTER. Thank you, Mr. Chairman, and thank all of you for being here. Mr. Coukell, Mr. Gaugh, I understand both of you are pharmacists; is that correct?

Mr. COUKELL. Yes, sir.

Mr. GAUGH. Yes, sir.

Mr. CARTER. Good, good. I want to talk about something. I want to talk about PBMs, pharmacy benefit managers, OK, one of my favorite topics. Mr. Coukell, you say in your written testimony here, pharmacy benefit managers, the middlemen, that insurers and employers pay to both administer prescription drug benefits and negotiate discounts from drug companies play a crucial role, using their large sales volumes and their ability to create formularies to force drug companies to offer deep price concessions. However, a share of the savings accrues to the pharmacy benefit managers themselves, and their contracts can be extremely complex, making it difficult even for sophisticated benefits administrators to determine whether they have achieved optimal savings.

Let me ask you, when you have three companies that control almost 80 percent of the market, as we have here in this country where we have three PBMs that control 80 percent of the market, wouldn't you agree that that is not much competition there? If you look at the pharmacy benefit managers and you look at their profits over the years, you see that they have exploded, that they have profits that have increased over 600 percent. Obviously they are not doing what they were supposed to have done.

Now you go on to say that Congress could consider requiring greater transparency of contract terms and definitions between payers and pharmacy benefit managers. Such a bill has been introduced by Representative Doug Collins of Georgia, the MAC Transparency bill that will call for more sunlight to be shed, for more transparency in our drug pricing system. I would like to just get your comments on that if you would about how that could help us in bringing down drug prices.

Mr. COUKELL. Thank you for that question. PBMs with their negotiating power play an important role in bringing down drug prices, and then the important question is, is the ultimate payer, the self-insured employer or the insurance plan, getting adequate benefit? And of course the PBMs have to make some money in that deal too. That is their business model.

In my testimony in calling for transparency that was not calling for public transparency on the price, but because these contracts are so complex and they have so many fees, the question is are there standards around contract definitions as well as audit mechanisms and standards around lack of conflict of interest in the peo-

ple who advise on PBM contracts that could be beneficial to the ultimate payer.

Mr. CARTER. And listen, I don't have any trouble with anybody making money, more power to them, and that is not what I am getting at. But what I am getting at is that this is a shell game. They are ripping off the public, I am telling you, and that is what is happening with the PBMs. They are not achieving what they set out to achieve and what we think they are achieving by bringing down drug prices, because they are not passing them on.

Yet they avoid transparency, and this is what this legislation is trying to do. There has to be transparency within the marketplace. I will give you an example. We had the problem as you are well aware of, of the EpiPen that went up to like $600 for a two-pack. And when I was on the Oversight Committee we had the CEO of EpiPen of Mylan Pharmaceuticals, the manufacturer of that product, testify before us and she is at the beginning, I as a pharmacist, I was at the end.

So she says, OK, when it leaves us this is what the price is—and I am going to just make up a number, $150—when it gets to me it is $600. What happens in between? That is what we are trying to figure out. In between is that man behind the curtain. In between is the PBM. They are the ones who are marking that drug up and not passing it on. This is causing a problem in the market, in the generic drug market. This is one of the reasons why prescription drug prices are so high.

And this is why Representative Collins' bill, I think, is so essential and that we should pass it here in Congress, the MAC Transparency bill. Again I am not opposed to anybody making money, but I am opposed when they are causing the public the distress that they are causing them by increasing drug prices the way that they are.

Now there are others who need to be held responsible, including pharmacists, including pharmaceutical manufacturers, all of us have a part in this. But the transparency needs to happen. It needs to happen not only so we can bring down drug prices, but the things that is going to bring down healthcare costs all together in our healthcare market is going to be more competition. That is why this hearing is so important.

How can we bring about more competition within the generic drug market within health care itself? That is what we are working on right now in Congress when we are talking about health care and we are talking about all the things that we are talking about here. How do we increase competition so that we can bring down costs? One way we do that is through encouraging more competition within the generic drug marketplace. That is what we have got to do. That is going to bring the prices down.

Just one quick example of how it does that in my own life. When I was still practicing I had this little company down the road who decided they wanted to get involved and wanted to become a player in the pharmacy market. I think the name of the company was Walmart. They came up with this. We are going to give you a 30-day prescription, a 30-day supply of generics for $4. I thought they were crazy. I said man, there is no way. I can't even buy it that

cheap. I bowed my back and I said there is no way I am going to do that.

Well, guess what. A week later I was doing it. A week later I called my suppliers and I said you have got to do something. I have people walking down to that store and I am not going to have that. That is the way you drive down drug prices, through more competition, through more manufacturers, generic drug manufacturers on the market. That is the answer.

Thank you. I am sorry, I didn't mean to go on, but thank you very much.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman and recognizes the gentleman from Oregon, Dr. Schrader, 5 minutes for your questions, please.

Mr. SCHRADER. Thank you very much, Mr. Chairman. Dr. Gaugh, just to confirm, in the previous session, previous panel, Dr. Woodcock indicated there might be in the neighborhood of 183 sole-source drugs where there is no generic competition. Would you agree with that number, roughly?

Mr. GAUGH. Roughly, yes.

Mr. SCHRADER. All right. Could you talk briefly about the pre-ANDA meetings and the increased communication and GDUFA and how you see this new process working out to make it even better?

Mr. GAUGH. Yes, in the pre-ANDA meetings it gives the industry the opportunity to meet with the FDA prior to actually filing the application with the FDA. It could be one or more meetings. Those meetings allow that conversation back and forth between the agency and the industry so that they can determine if they are taking the right path, or maybe they need to make a slight move in that path forward so when they do file their application the application is usually substantially complete and we would anticipate a first-cycle review of that.

Mr. SCHRADER. Good, very good.

Ms. Holcombe, one portion of our bill, Lower Drug Costs Through Competition Act, trying to close a loophole in the tropical disease priority review process. Some bad actors have announced plans to access brand name priority review vouchers by buying the rights to manufacture a drug from overseas and then bring it back to the U.S. for approval without having to do any additional research or development.

Would you agree that this program was intended to act as an incentive for new research, new drugs in the U.S. market, not just merely to adopt something from overseas?

Ms. HOLCOMBE. I would agree that this program was intended to ensure that U.S. patients affected by these tropical diseases would be able to access safe and effective drugs to treat them. Our concern about the provision as it currently is written is worrying about taking away from FDA the ability to decide on an application-by-application basis what data are needed to provide an approval for a drug.

So there may be cases where a company has perfectly legitimately marketed a drug and had it approved first in a country where these diseases are endemic, and then brings this application

to the U.S. because U.S. patients are now being affected from, because they travel out of the country, for example.

But if there have been legitimate, good, solid clinical studies that already have been done that are applicable to the U.S. patients who are affected by this condition, FDA will decide that maybe we don't need additional studies. If FDA has a different view, then of course they should be able to say to the company you need to do new studies. And sometimes that is going to happen for various reasons.

Mr. SCHRADER. And that is what our bill, I think, is trying to get at, give FDA the final say——

Ms. HOLCOMBE. Yes.

Mr. SCHRADER [CONTINUING]. Using whatever appropriate studies are out there. Dr. Gaugh, a question on the risk management strategies and studies that we are trying to put in our legislation. Do you have any idea about the number of companies that may be restricted from accessing the market because of the REMS current provisions?

Mr. GAUGH. There is somewhere in the realm of 80 to 95 companies that have the restricted REMS.

Mr. SCHRADER. Oh, so a substantial number.

Mr. GAUGH. And then there is another probably 40 to 45 companies that have a restricted distribution set up, but it is not part of the REMS system.

Mr. SCHRADER. Very good. And with that I yield back, Mr. Chair, thank you. Thank you, all.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions, please.

Mr. LANCE. Thank you, Mr. Chairman. Good afternoon to the panel. Mr. Gaugh, following up on the chairman's questioning, do you believe it will be helpful for the FDA to have more presubmission meetings for noncomplex priority submissions?

Mr. GAUGH. I think the answer to that is it would always be more helpful, yes. I think it is a more complex process than that. As we talked earlier, there is around a thousand applications that are filed every year, and with a thousand applications and having one or two or three meetings with the FDA on a thousand different products, probably so resource restrictive it couldn't happen.

So in GDUFA II we agreed to start this process in complex products, explore it and then we will move forward from there.

Mr. LANCE. Thank you. Is there anyone else on the panel who would care to comment? Thank you. Again Mr. Gaugh, in your opening statement you mentioned a more effective generic drug review program as a goal of your organization. Touching on GDUFA II pre-ANDA submission communications pathway and information requests and division review letters, do you think these initiatives will reduce review cycles and what are the additional ways your organization believes the FDA sponsored dialogue could be enhanced?

Mr. GAUGH. So the potential does exist for that increased review and decreased cycle review time. In GDUFA I those information requests and division review letters were not part of the process, but we did negotiate with the FDA early on in GDUFA I to have them begin doing that which they did. So we have now codified that in

GDUFA II, so that does give us the opportunity during a review cycle, whether it is chemistry, microbio equivalence, for the reviewer to give an information request, for example, to a company who would then have roughly 15 days to respond and that could then move it right on in that still first-cycle review process.

Mr. LANCE. Thank you.

Ms. Holcombe, good afternoon. It is always a pleasure to be with you. In your testimony you note that BsUFA II addresses the hiring issue which should result in improved processes and faster review times. Given that the reviewers are the same as PDUFA reviewers, do you believe the goals set out need to have any potential bandwidth issues for reviewers, or can we work together in that regard?

Ms. HOLCOMBE. So BsUFA will benefit from the hiring goals that are included in the PDUFA agreement that this committee is going to consider at a subsequent hearing because of the fact that the reviewers are the same.

Mr. SCHRADER. Are the same, yes.

Ms. HOLCOMBE. One of the issues with getting biosimilar products has been that these, when FDA was not sufficiently staffed in CDER and CBER in general, these reviewers who were reviewing two categories of products now just were simply overwhelmed. So we need to have changes in the hiring processes, we need to have some of the changes in 21st Century Cures, and we need to be sure that FDA is going to be able to meet those annual commitments for hiring.

Mr. SCHRADER. Thank you. And I am so pleased that we don't have acronyms here in this——

Ms. HOLCOMBE. We don't use acronyms.

Mr. SCHRADER. Acronyms, no. Thank you very much, Mr. Chairman, and I yield back the balance of my time.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. ESHOO. Thank you, Mr. Chairman. First, thank you to each witness. You did a terrific job. And I want to point out something that maybe some of you don't know, maybe everybody does. But even if everybody does, it is still worth saying it for the record, and that is that Kay Holcombe said when she began her testimony it is such an honor to be here. Here was her home. Kay Holcombe is one of the most distinguished individuals to have served on the staff of the Energy and Commerce Committee.

And I remember so well the farewell reception for Kay, boo-hoo, we were all boo-hooing. But that reception was filled with Republican senators, Democratic senators, Republican House members, Democratic House members. I mean, the breadth and the depth of her knowledge, her professionalism, and that recognition on a bipartisan basis is something that I will never forget. And I don't think there are that many people that could bring that kind of a crowd together. So she is a superb professional and you know what, Kay, it is in honor to see you. And I waited so I could say this. I waited so I could say this because I have got to get out to Dulles, and wheels up and westward bound.

There is something in listening to the testimony of everyone here today, and members almost to a person have spoken about how the generic industry has grown, what it offers the American people. That generic drugs now account for 89 percent of prescriptions that are dispensed in the United States and that it saved the United States healthcare system almost, just rounding it off when you are talking about trillions, right, $1.5 trillion. That is not just walking-around money. That is not just loose change. And that is a period of over a decade.

So my question to you is, that is a huge number and the savings are huge. Why do we have such a problem with the pricing of drugs in the country? They should be coming down not going up, according to these statistics. Can any of you speak to that?

Mr. LEICHER. I could speak to it from a biologics perspective.

Ms. ESHOO. Short, because I have another question too.

Mr. LEICHER. We don't yet have the biosimilars pathway up and running at the full tilt, essentially, as Kay spoke to earlier.

Ms. ESHOO. I know that one very well, believe me. I have shot more bullets across the bow on it.

Mr. LEICHER. And with the change in mix in products heavily to the biologics end of the spectrum, without this we had savings from generics.

Ms. ESHOO. Well, how much of the generic industry would you say that biologics is?

Mr. LEICHER. How much of the generics industry is biologics? I am not sure I understand the question.

Ms. ESHOO. Well, you are saying that biosimilars have really not arrived yet and I agree with you.

Mr. LEICHER. In the market——

Ms. ESHOO. The Obama administration dragged their heels. I don't know what this administration is going to do. We don't have interchangeability. The pricing is what CMS has done and I think they screwed it up. So, it is not good, I don't think. I would give it a C- so far.

Mr. LEICHER. What I would say is the majority of the highest selling products today are shifted over to the biologics end of the spectrum, so the opportunity to capture savings from generic substitution has declined as the biologics have taken the lead.

Ms. ESHOO. I appreciate what you have said. I am not so sure that I, in terms of the numbers that are stated and where we are in terms of drug prices, I don't know. Is there a fact gap in this, Kay? Do you want to take a stab at it?

Mr. GAUGH. I think it is key to point out the——

Ms. ESHOO. Is your name Kay?

Mr. GAUGH. Sorry. No, it isn't.

Ms. ESHOO. Kay.

Ms. HOLCOMBE. I don't know whether, there are some fact gaps which are much longer than a 5-minute conversation, but I do think that increased competition in the marketplace is going to drive down prices. And as Bruce pointed out, the biologics marketplace is at the chic end of the spectrum and as we have more biosimilars entering that marketplace I think we are going to see a difference. With the number of programs in development now, my speculation is that these programs represent the top used and the

top selling biological products. These are the ones that are going to have biosimilars first. And I think we will, by the end of this next 5-year period we will be able to predict much more accurately what is going to happen in terms of the overall marketplace as we get more of these products on the market.

Ms. ESHOO. Thank you very much. My time is up. Thank you, everyone. Have a great weekend.

Mr. BURGESS. The gentlelady yields back. The chair thanks the gentlelady. Before I yield to the gentleman from New Jersey, Mr. Gaugh, did you have something you wanted to offer us?

Mr. GAUGH. I was just going to point out the facts that you are talking about. So 11 percent of the products on the market account for the opposite of 27, so 11 percent of the products on the market, the brand products, account for 63 percent of the dollars that are being spent. And those prices you see going up all the time, whereas in generics that is where the savings report comes. You see the savings from the generics and the prices typically going down and competition is what drives that. Thank you.

Mr. BURGESS. The chair thanks the gentleman, and the chair recognizes the gentleman from New Jersey for 5 minutes for questions, please.

Mr. PALLONE. Thank you, Mr. Chairman. As I mentioned earlier with the first panel, I believe as this committee looks at policies to encourage and support robust generic competition that we must also examine the barriers that are currently preventing generic access.

And so if I could start with Mr. Gaugh—I hope I am pronouncing it right. In her testimony, Dr. Woodcock noted that certain brand companies are using REMS programs to delay or deny generic manufacturers access to reference product. Can you please discuss further ways, or the ways in which certain brand companies directly or indirectly refuse access to the reference product for generic drug development?

Mr. GAUGH. Yes, thank you. In the REMS program they are set up under—and not all REMS. There are multiple different levels of REMS. But in the REMS ETASU programs they are set up where they are restricted distribution programs. It is much like an early drug investigational review product where you keep tight controls so that you know exactly where each tablet, capsule, injectable vial went to from a patient standpoint.

They have done the same thing in the REMS, and so when you try to buy or try to purchase that since you are not a qualified patient, if you will, you don't get access to those drugs. And even though the REMS was not set up for that and there is a process currently where you contact the FDA, the FDA writes a letter to the company, that is really the only thing that happens. There is no stick to that, if you will.

Mr. PALLONE. Thank you. I didn't realize that Dr. Woodcock was here. I really love the fact you stay for the second panel. You are one of the few people that does that.

Mr. Leicher, I also understand—well, I want to ask you something about utilizing restricted distribution programs also, but that was a tactic that Turing was utilizing to block competition to Daraprim. Can you discuss how certain brand companies are using

the restricted distribution practices also to block access to reference product and the types of product that these practices are being used for?

Mr. LEICHER. Well, thank you for the question, and what I would like to add to is this is not just a REMS problem, and it is actually a much bigger problem, actually, in many respects, in the biosimilars business, because when we are developing generic drugs we need a smaller quantity to do analytical testing.

When we are developing biosimilars we have to do clinical trials with blinded vials and purchase very large quantities to do the adequate studies. And when you call a wholesaler to purchase a drug with an adequate medical license or pharmacist license, what you are finding increasingly today is wholesalers saying we can't sell it to you because you are doing biosimilar testing. And when we ask why, it is because they have to provide our name to the manufacturer and the manufacturer says you can't supply it.

And that is the reason why we are very, we strongly support the FAST Generics Act or the CREATES Act as a solution to make that practice unlawful, because it ought to be a condition of approval that products are made available to licensed regulated companies by the FDA to develop biosimilars.

Mr. PALLONE. OK, thanks. One more question of Mr. Coukell. In your testimony you discussed a landscape with a number of different drug pricing challenges including launch prices and year-over-year increases. You have also talked about the need to increase generic competition, specifically policies to ensure generic companies have access to samples of the reference product for bioequivalence testing. Could you describe how that policy could be implemented in a way that yields the most savings?

Mr. COUKELL. Yes, sir. So first of all, REMS are there to protect patients and we have to make sure that those protections remain in place, but that is completely doable. And then there is sort of two pieces to it. One is, can the generic company get access to the product for purposes of testing, and there is a number of mechanisms and a couple have just been mentioned in the pieces of legislation that were mentioned. And then the second piece is can the company marketing the product that is under a REMS have access to the REMS program itself which is another barrier.

So they have to be able to get the product for testing and then they either have to be able to negotiate their way into a shared REMS program or stand up their own independent REMS program, and the FDA needs discretion to help them find the right solution on that latter part.

Mr. PALLONE. OK. Well, I want to thank you all and thank the chairman also, because it is my hope that the committee continues to discuss legislation to promote generic competition and that we also consider policies that will address the use of REMS as a barrier for generic entry.

One of the concerns I have, Mr. Chairman, is I am starting to hear from different people who will say, well, generics aren't really a factor in trying to keep drug prices down, and I continue to believe that they are. I am kind of shocked by the fact that even some of my colleagues will say that they are not. So I think it is impor-

tant, the things that we are discussing today and in the future. Thanks again.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. And seeing that there no further members wishing to ask questions, I do want to thank our witnesses for being here today. It was a long hearing and I appreciate your indulgence.

Two unanimous consent requests, or three unanimous consent requests from Mr. Schrader to enter into the record a letter from Premier, an alliance of 3,700 hospitals [1]; the American Academy of Ophthalmology [2]; and a letter from the American Academy of Dermatology. [3] And then further, Mr. Long of Missouri had asked that we include a letter from the Federal Trade Commission in the record. So, without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. Pursuant to committee rules, I remind members they have 10 business days to submit additional questions for the record. I ask the witnesses to submit their response within 10 business days upon receipt of the questions. And without objection, the subcommittee stands adjourned.

[Whereupon, at 2:03 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

[1] The information was unavailable at the time of printing.
[2] The information was unavailable at the time of printing.
[3] The information was unavailable at the time of printing.

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Economics
Bureau of Competition

March 7, 2014

Via Electronic Submission

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4159-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

**Re: Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs**

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition (collectively, "FTC staff" or "staff"),[1] are pleased to respond to your January 10, 2014 request for comments on "Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" ("Proposed Rule").[2] In its request, CMS observes that, in establishing the Medicare prescription drug program, Congress sought "to promote competition in the private market for Part D drugs."[3] We write to share our perspective on the "any willing pharmacy" provisions in the Proposed Rule,[4] in light of FTC staff experience examining competition issues and the workings of private markets for prescription drugs.

The issue CMS has raised in proposing these provisions is an important one. The ability of health plans to construct networks that include some, but not all, providers (so-called "selective contracting") has long been seen as an important tool to enhance competition and lower costs in markets for health care goods and services. Both economic principles and empirical evidence support that view.

The proposed any willing pharmacy provisions threaten the effectiveness of selective contracting with pharmacies as a tool for lowering costs. Requiring prescription drug plans to contract with any willing pharmacy would reduce the ability of plans to obtain price discounts based on the prospect of increased patient volume and thus impair the ability of prescription drug plans to negotiate the best prices with pharmacies. Evidence suggests that prescription drug prices are likely to rise if Prescription Drug Plans ("PDPs") are less able to assemble selective pharmacy networks. The proposed provisions may also hinder the ability of plans to steer beneficiaries to lower-cost, preferred pharmacies and preferred mail order

vendors through financial incentives or other terms. Finally, Medicare beneficiaries may also have fewer choices if the any willing pharmacy provisions change the incentives of PDPs and result in fewer plans competing in the Part D marketplace. Specifically, beneficiaries who are willing to accept coverage under a plan with a narrow network of preferred pharmacies in exchange for lower costs may be deprived of that option. We are therefore concerned that the proposed any willing pharmacy provisions may threaten to harm competition and Medicare beneficiaries.

CMS has suggested that the proposed any willing pharmacy provisions are needed in part because its data show that limited networks of pharmacies do not consistently achieve greater savings than broad networks. We support the goal of ensuring that selective contracting by Medicare Part D plans does not misalign incentives and contribute to higher costs. In addition, we recognize there are constraints on CMS rulemaking. However, we urge CMS to proceed cautiously before concluding that an any willing pharmacy rule is the way to address its concerns. We share this concern with the Medicare Payment Advisory Commission, which has advised CMS of "several programmatic changes" other than any willing provider provisions to "ensure that the use of tiered pharmacy networks do not increase Medicare costs and do not harm beneficiaries."[5]

CMS studies have found substantial savings associated with preferred pharmacies and mail order pharmacies on average, which is generally consistent with independent research on selective contracting. If some subset of plans are not achieving the expected costs savings, that does not mean that the basic premise of selective contracting is unsound or that an any willing pharmacy rule is the solution. In the view of FTC staff, an any willing pharmacy rule likewise may not serve to address other important objectives that CMS identifies in its request for comment.

If the proposed any willing pharmacy provisions are implemented and result in higher Medicare costs, all American consumers – not just Medicare beneficiaries – may feel the effects of diminished Part D competition, given the substantial impact of Medicare spending on the federal budget.

## I. Interest and Experience of the Federal Trade Commission

The Federal Trade Commission ("FTC" or "Commission") is an independent agency responsible for maintaining competition and safeguarding the interests of consumers. Congress has charged the FTC with enforcing the FTC Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[6] Pursuant to its statutory mandate, the FTC seeks to identify business practices and government regulations that may impede competition without offering countervailing benefits to consumers. Competition is at the core of America's economy,[7] and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products, and greater innovation.

Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets, including pharmaceutical markets,

has long been a focal point of FTC law enforcement,[8] research,[9] and advocacy.[10] FTC staff continue to monitor economic research on issues regarding, for example, selective contracting, pharmacy benefit managers ("PBMs"), mail order and "brick and mortar" retail pharmacies, and related issues.[11] Based on the FTC's study and research (including reviews of pertinent economic literature), FTC staff also have analyzed certain state-level statutory and regulatory any willing provider and "freedom of choice" ("FOC") policy proposals, many of which have mirrored the any willing pharmacy provisions in the Proposed Rule.[12]

## II. Background: "Any Willing Provider" and "Freedom of Choice" Laws

CMS proposes to require that PDPs offering preferred cost sharing permit "any willing pharmacy the opportunity to offer preferred cost sharing if the pharmacy can offer the requisite level of negotiated prices."[13] CMS also proposes publication of preferred and non-preferred prices, terms, and conditions. The rules require that variation of these terms or tiers be restricted such that, "[f]or prescriptions not subject to Long Term Care, specialty pharmacy, or home infusion pricing, … [there will be] three authorized levels of cost sharing: Standard, preferred, and extended days' supplies for retail and mail order pharmacies."[14] These proposed regulations generally mirror those found in some state-level any willing provider and FOC laws.[15]

FTC staff have previously expressed concerns about potential anticompetitive effects and consumer harm associated with any willing provider and FOC laws.[16] Although more limited networks may sometimes limit patient choice, any willing provider and FOC laws can make it more difficult for health insurers, plans, or PBMs to negotiate discounts from providers, resulting in higher costs. If plans cannot give providers any assurance of favorable treatment or greater volume in exchange for lower prices, then the incentive for providers to bid aggressively for the plan's business – by offering better rates – is undermined.[17] At the same time, any willing provider and FOC provisions may also reduce incentives for plans to invest in plan designs and complex negotiations with pharmacies and manufacturers. Any willing provider and FOC provisions can therefore undermine the ability of plans to reduce costs. This is likely to result in higher negotiated prices, ultimately harming consumers. Any willing provider and FOC laws can also limit competition by restricting the ability of insurance companies to offer consumers different plans, with varying levels of coverage, cost, and choice. These restrictions on competition may result in insurance companies paying higher fees to providers, which generally lead to higher premiums, and may increase the number of people without coverage.

Both economic theory and empirical evidence suggest that any willing provider and FOC provisions are likely to have these negative effects.[18]

## III. Research Demonstrates that There Are Savings Associated with Preferred Pharmacies and Mail-order Pharmacies, and that Any Willing Provider Regulations Tend to Increase Costs

Basic economic principles suggest that a buyer can obtain a negotiating advantage by contracting selectively with a subset of providers. Empirical studies regarding the contracting

and pricing practices of pharmacies and other health care providers support the theory, as providers are willing to offer lower prices in exchange for increased volume.

**a. CMS Studies of Medicare Part D Plans**

CMS has released two studies analyzing prescription drug data from March 2012 for Medicare Part D plans. Both studies concluded that selective contracting has resulted in lower prices on average. These studies sought to compare the prices negotiated by plan sponsors with pharmacies under varying contractual arrangements. The first study, released in April 2013, focused on plans with pharmacy networks that included preferred and non-preferred pharmacies. The purpose of the study was to determine whether the increased cost sharing offered at preferred pharmacies – *i.e.*, lower copayments for beneficiaries – resulted in increased payments to the plans from the program.[19] The second study, released in December 2013, performed a similar analysis focused on comparing negotiated prices at retail pharmacies and mail order pharmacies.[20] The impetus for this research was "individual complaints about some drug costs being higher in preferred pharmacies."[21]

The CMS studies considered whether Part D plans encourage beneficiaries to fill their prescriptions at higher-priced pharmacies, raising costs for the program. In the first study, CMS compared various measures of unit cost for the top 25 brand and top 25 generic drugs for prescriptions filled at preferred pharmacies and prescriptions filled at non-preferred pharmacies under 13 PDP contracts. CMS found that, on average, branded drugs cost 3.3 percent less at preferred pharmacies and generic drugs, on average, cost 11 percent less at preferred pharmacies. However, CMS also found that average drug costs were higher in preferred pharmacies for five of the 13 PDP contracts it examined. Although these five contracts accounted for more than one-third of the contracts studied, they only accounted for about four percent of the claims in the CMS sample. CMS's second study considered costs for the same 50 drugs under 57 PDP contracts with mail order benefits. Taking the average across all 57 contracts, CMS found that the weighted average unit cost was 16.4 percent lower in mail order pharmacies than retail pharmacies for brands and generics combined, and 11 percent lower for generics. Despite the lower average costs, costs were higher for drugs purchased through mail order pharmacies for 21 contracts.

In both studies, CMS found substantial savings on average associated with preferred pharmacies and mail order pharmacies. This finding is generally consistent with the independent research on selective contracting discussed below. Despite these findings, CMS appears to conclude that selective contracting is of limited value because costs appear to be higher in either preferred or mail-order pharmacies under certain plans. FTC staff agrees that these studies may signal a problem that merits further investigation and appropriate intervention. However, we caution against using the finding that not all preferred or mail-order pharmacies have offered lower prices as a basis to adopt a broad rule that undermines the use of selective contracting and may threaten the lower costs that result overall.

In addition, we note that in both of these CMS studies, none of the unit cost measures used controlled for the mix of drugs dispensed at different types of pharmacies. The types of drugs dispensed via mail order can be significantly different than those dispensed at "brick

and mortar" retail pharmacies.[22] Generally, mail order pharmacies dispense a greater relative proportion of "maintenance drugs" used to treat chronic or recurring ailments while retail pharmacies dispense a greater relative proportion of drugs for acute or short-term ailments. For example, it would be unusual to use a mail order pharmacy to fill a prescription for antibiotics to treat an emergent infection. On the other hand, maintenance drugs, such as cholesterol-lowering statins, might be obtained via mail order relatively often.[23] It may also be the case that consumers are more responsive to enhanced cost-sharing for relatively expensive drugs. Therefore, beneficiaries may be more likely to fill more expensive prescriptions at preferred pharmacies. Average cost measures that do not account for the product mix may be misleading precisely because they do not disentangle differences in prices from differences in dispensing patterns. Without controlling for the product mix,[24] it is difficult to reach broad conclusions regarding the relative cost differences between different pharmacies.

We appreciate the importance of examining whether plan designs distort incentives for consumers to make cost-effective choices. The FTC considered these issues in its 2005 pharmacy benefit manager ("PBM") study, which examined whether pharmacy benefit designs properly align incentives between PBMs, plan sponsors, and enrollees. For example, the FTC study considered whether pharmacies owned by a PBM have the incentive to dispense more costly branded drugs, instead of low-cost generics. The data analysis in that study showed not only that beneficiaries and plan sponsors save money with generics, but that the PBM also earned higher profits when generic drugs were dispensed instead of branded ones.[25] The data showed that pharmacies owned by PBMs typically dispensed generics at rates comparable to pharmacies not owned by PBMs because their incentives to do so were similar.[26] The FTC study also found that, for example, "[a]fter controlling for prescription size and drug mix differences, mail prices are typically lower than retail prices."[27] The data used for the FTC study is now more than ten years old and predates the Part D benefit rollout, but it does support the need for continued analysis of potential misalignment of incentives or conflicts of interest in pharmacy benefit plan design.

**b. Research on Selective Contracting and the Costs of Any Willing Provider Regulations**

One related area in which selective contracting has been examined in the health care industry is in connection with hospital markets. Health plans build networks of hospitals to serve their beneficiaries, much as PDP sponsors assemble networks of preferred pharmacies. One study concluded that Connecticut health plans' ability to negotiate discounts with hospitals increased with the plan's willingness and/or ability to channel patients to selected hospitals, consistent with the predictions of a theoretical model introduced in the same study.[28] Another analysis found that Massachusetts health plans willing to be more selective in forming their hospital networks obtained deeper discounts.[29] These studies demonstrate that buyers in health care markets have effectively used selective contracting to negotiate lower prices.

In addition, two peer-reviewed studies analyzing state-by-state policy variation to measure the effects of any willing provider laws have confirmed that any willing provider

requirements undercut negotiating strategies. Research performed and published by an FTC economist has found, for example, that any willing provider laws generally undermine the ability of managed care organizations to lower health care spending. Specifically, the study found that per capita total health care expenditures are higher in states with any willing provider laws.[30] A 2009 study similarly examined variations in state any willing provider laws applicable to drug purchases to measure their effects. It found that states with any willing provider laws have higher prescription drug spending than those without them. The conclusion was the same, even when using different econometric techniques to account for variations across the states, such as differences in demographics, market structure, and regulatory environment.[31] Finally, a more recent working paper examined state-level per capita health expenditure data from CMS and found that any willing provider and FOC laws are associated with four percent higher per-capita drug expenditures.[32]

We recognize that limited networks do not "*per se* [lead] to significantly lower costs."[33] Yet the theoretical and empirical economic literature indicates that they can and do, on average, yield lower costs and prices.[34] At the same time, we understand that some PDPs elect, for various business reasons, to implement something akin to an any willing provider provision as part of their voluntary contracting,[35] and do not mean to suggest that such plan design options should be restricted.[36] As a policy matter, however, we hope that CMS will recognize the tendency of limited networks to yield lower costs and prices. We therefore urge CMS to preserve consumer choice by recognizing the potential advantages of selective contracting and limited networks where they work to the advantage of competition and consumers, and to be wary of any willing provider requirements, which can foreclose business models that aim to compete based on selected contracting and limited networks.

## IV. Conclusion

FTC staff appreciates the important task faced by CMS in implementing the laws regarding Medicare Part D plans. We appreciate, too, CMS's interest in striking "an appropriate balance between the need for broad pharmacy access and the need for Part D plans to have appropriate contracting tools to lower costs."[37] As we have noted, however, we are concerned that the any willing pharmacy provisions in the Proposed Rule may impair, rather than enhance, the ability of plan sponsors to negotiate lower prices. Based on FTC staff's experience in this area, as well as our review of empirical studies of preferred provider contracting and any willing provider and FOC laws, there are two clear and consistent conclusions in the literature:

- Selective contracting with pharmacies and other health care providers can lower prices paid by plans and their beneficiaries; and

- Any willing provider and FOC laws tend to raise prices or spending because they impair the ability of Part D plan providers to engage in selective contracting.

For this reason, we urge CMS to consider the issues raised in this letter to reassess whether its proposed any willing pharmacy provisions are likely to benefit Part D beneficiaries and the Part D program. Before proceeding with a full rollout of this any willing

provider pharmacy provision, CMS might consider whether further data analysis or new policy experiments might provide valuable information on the effects of these provisions on plans and beneficiaries.

Respectfully submitted,

Andrew I. Gavil, Director
Office of Policy Planning

Martin S. Gaynor, Director
Bureau of Economics

Deborah Feinstein, Director
Bureau of Competition

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[1] This comment expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. It does not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. Commissioner Brill is dissenting from the filing of this comment.

[2] 79 Fed. Reg. 1918 (Jan. 10, 2014) [hereinafter Proposed Rule].

[3] Proposed Rule 79 Fed. Reg. at 1969 (Jan. 10, 2014) (discussing the non-interference provision); *see also id.* at 1979, 1982 (noting CMS's desire to "maximize opportunities for price competition" and "improve market competition" through proposals on any willing pharmacy standards).

[4] We focus here on the "Any Willing Pharmacy Standard Terms & Conditions (§423.100(a)(8))" discussed in Part 29 of the Proposed Rule, 79 Fed. Reg. 1978-82, and their likely competitive consequences.

[5] MedPac Public Comment on Contract Year 2015 Policy and
Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, Proposed Rule (Feb. 28, 2014), *available at* http://www.medpac.gov/documents/02282014_partD_COMMENT.pdf.

[6] Federal Trade Commission Act, 15 U.S.C. § 45.

[7] *See* Standard Oil Co. v. FTC, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").

[8] *See generally, e.g.,* FTC, An Overview of FTC Antitrust Actions In Health Care Services and Products (Sept. 2010), *available at* http://www.ftc.gov/bc/110120hcupdate.pdf; *see also* FTC, Competition in the Health Care Marketplace: Formal Commission Actions, *available at*
http://www.ftc.gov/bc/healthcare/antitrust/commissionactions.htm.

[9] *See, e.g.*, FTC & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Ch. 7 (2004), *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf. The 2004 Report was informed by extensive hearings on health care markets – including pharmaceutical and insurance markets – that were jointly conducted by the FTC and DOJ in 2003, as well as an FTC-sponsored workshop and independent research. Information on the 2003 Hearings on Health Care and Competition Law and Policy is *available at* http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm. Of particular relevance to our discussion of the Proposed Rule and any willing provider provisions is the Commission's 2005 "Conflict of Interest Study" regarding pharmacy benefit managers, and the Commission's subsequent report on pricing and contracting practices for mail-order and brick-and-mortar pharmacies. *See* FEDERAL TRADE COMMISSION, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (Aug. 2005) [hereinafter FTC PBM STUDY] at 25, 31-36, *available at* http://www.ftc.gov/reports/pharmbenefit05/050906pharmbenefitrpt.pdf.

[10] FTC and staff advocacy may comprise letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. *See, e.g.*, FTC Staff Letter to Hon. Mark Formby, Mississippi House of Representatives, Concerning Mississippi Senate Bill 2445 and the Regulation of Pharmacy Benefit Managers (Mar. 2011), *available at* http://www.ftc.gov/os/2011/03/110322mississippipbm.pdf; FTC and DOJ Written Testimony before the Illinois Task Force on Health Planning Reform Concerning Illinois Certificate of Need Laws (Sept. 2008), *available at* http://www.ftc.gov/os/2008/09/V080018illconlaws.pdf; FTC Amicus Curiae Brief in *In re Ciprofloxacin Hydrochloride Antitrust Litigation* Concerning Drug Patent Settlements Before the Court of Appeals for the Federal Circuit (Case No. 2008-1097) (Jan. 2008), *available at* http://www.ftc.gov/os/2008/01/080129cipro.pdf; FTC & DOJ, A DOSE OF COMPETITION, *supra note* 9.

[11] FTC PBM STUDY, *supra* note 7; *see also* GENERAL ACCOUNTING OFFICE, EFFECTS OF USING PHARMACY BENEFIT MANAGERS ON HEALTH PLANS, ENROLLEES, AND PHARMACIES 9 (Jan. 2003) [hereinafter GAO REPORT], *available at* http://www.gao.gov/cgi-bin/getrpt?GAO-03-196.

[12] *See, e.g.*, FTC Staff Comment to the Honorable James L. Seward, Concerning New York Assembly Bill 5502-B to Regulate the Use of Mail Order Pharmacies by Health Plans Offering Prescription Drug Coverage (Aug. 2011), *available at* http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-james-l.seward-concerning-new-york-assembly-bill-5502-b-regulate-use-mail-order-pharmacies-health-plans/110808healthcarecomment.pdf.

[13] Proposed Rule, 79 Fed. Reg. at 1978.

[14] *Id.* at 1981.

[15] Generally, any willing provider laws require health plans to include in their networks any provider that is willing to participate in accordance with the plan's terms. *See, e.g.*, Michael Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of 'Any Willing Provider' Regulations*, 20 J. HEALTH ECON. 955, 956 (2001). FOC laws are similar, but are directed at health plan reimbursements instead of providers. FOC laws require plans to reimburse for health care goods or services obtained from any qualified provider, even if the provider is not one of the plan's preferred providers, or is not a member of the plan's network. *Id.* Some states have adopted such laws for pharmacy services, although the laws vary substantially. *See, e.g.*, Anne Carroll and Jan M. Ambrose, *Any-Willing-Provider Laws: Their Financial Effect on HMOs*, 27 J. Health Pol., Pol'y & L. 928 (2002). Other states have adopted similar laws for other types of health care benefits. Due to limitations of the available data, the literature tends to look at the effect of any willing provider laws on total spending, instead of prices. Because the quantity of health care is generally measured to have a negative, though small, relationship with health care prices, these studies likely understate the effect of any willing provider laws on prices.

[16] *See, e.g.*, FTC Staff Comment to the Hon. Nelie Pou Concerning New Jersey A.B. A-310 to Regulate Contractual Relationships Between Pharmacy Benefit Managers and Health Benefit Plans (Apr. 2007) [hereinafter New Jersey Comment], *available at* http://www.ftc.gov/be/V060019.pdf; FTC Staff Comment to the Hon. Terry G. Kilgore Concerning Virginia House Bill No. 945 to Regulate the Contractual Relationship Between Pharmacy Benefit Managers and Both Health Benefit Plans and Pharmacies (Oct. 2006), *available at*

http://www.ftc.gov/be/V060018.pdf; Letter from FTC Staff to Patrick C. Lynch, Rhode Island Attorney General, and the Hon. Juan M. Pichardo, Rhode Island State Senate (Apr. 8, 2004) [hereinafter Rhode Island Comment], *available at* http://www.ftc.gov/os/2004/04/ribills.pdf.

[17] *See* New Jersey Comment, *supra* note 16, at n. 36 and accompanying text; Rhode Island Comment, *supra* note 16, at 6; *see also* Aaron S. Edlin & Eric R. Emch, *The Welfare Losses from Price-Matching Policies*, 47 J. IND. ECON. 145 (1999). Such negotiations on behalf of health plans often are handled by PBM companies or by insurer-owned, or retailer-owned, providers of PBM services. *See generally* FTC PBM STUDY, *supra note* 9, at Ch. 1.

[18] For example, one study found that expenditures rise when any willing provider or FOC laws are enacted, and tend to rise more with stronger laws. Vita, *supra* note 15, at 966 (panel data showing, e.g., that states with highly restrictive any willing provider/FOC laws spent approximately 2% more on healthcare than did states without such policies). As Vita notes, empirical studies of the effects of such laws are few. *Id.* at 956. A 2005 Maryland study, however, examined in particular the effects of these types of statutory impediments to mail order provision of, for example, maintenance drugs. According to the Maryland report, greater use of mail order maintenance drugs – enabled by liberalizing Maryland insurance law – would save Maryland consumers 2-6% on retail drug purchases *overall*, and third-party carriers 5-10%. *See* MD. HEALTH CARE COMM. AND MD. INS. ADMIN., MAIL-ORDER PURCHASE OF MAINTENANCE DRUGS: IMPACT ON CONSUMERS, PAYERS, AND RETAIL PHARMACIES 2-3 (Dec. 23, 2005) [hereinafter MARYLAND REPORT].

[19] Part D Claims Analysis: Negotiated Pricing Between Preferred and Non-Preferred Pharmacy Networks (April 30, 2013), *available at* http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/PharmacyNetwork.pdf (last checked Feb. 24, 2014).

[20] Part D Claims Analysis: Negotiated Pricing Between General Mail Order and Retail Pharmacies, *available at* https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Negotiated-Pricing-Between-General-Mail-Order-and-Retail-PharmaciesDec92013.pdf (last checked Feb. 24, 2014).

[21] Part D Claims Analysis: Negotiated Pricing Between Preferred and Non-Preferred Pharmacy Networks, *supra note 19*, at 1.

[22] *See, e.g.*, FTC PBM STUDY, *supra note* 9, at 25-26, 31-32.

[23] In fact, this is exactly what the FTC found in 2004 when analyzing dispensing patterns across therapeutic classes in the PBM study. Nearly 100% of prescriptions for certain classes of antibiotics and for cold/cough medicines were dispensed via retail pharmacies whereas almost 50% of osteoporosis drugs and statins were dispensed via mail. *See* FTC PBM STUDY, *supra note* 9, at 32, Figure II-5. Also a quick look at the drug level claims data reported in Table 2 of the first CMS study shows that there can be considerable variation in dispensing patterns between preferred and non-preferred pharmacies as well. For instance, the total branded claims in preferred pharmacies are approximately 500,000 and the non-preferred total is around 300,000, so non-preferred claims are about 40% lower across all branded drugs. However, the 7th largest branded drug, ProAir HFA, has nearly an equal number of claims in preferred and non-preferred pharmacies (27,820 versus 27,522).

[24] A more informative way to perform this analysis would be to construct a price index based on a common market basket so that the mix of products is kept constant across the comparison groups, and differences in the price index reflect actual price differences. For a discussion of different methods to calculate a market basket, see "Alternative Weighting of the Hospital Market Basket Input Price Index", Office of the Actuary, CMS, November 13, 2008, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/alternativeindexweights.pdf.

[25] FTC PBM STUDY, *supra note* 9, at 71-76.

[26] *Id.* at 62-71 (discussing observed generic substitution rates and generic dispensing rates).

[27] *Id.* at 25. For a general overview of retail and mail-order pharmacy pricing, see Chapter II of the report, *id.* at 23-39.

[28] Alan T. Sorensen, *Insurer-Hospital Bargaining: Negotiated Discounts in Post-Deregulation Connecticut,* 51 J. INDUS. ECON. 469 (2003) (building a simple theoretical model describing the dynamics of the bargaining effects and testing it with data on negotiated Connecticut hospital discounts).

[29] Vivian Y. Wu, *Managed Care's Price Bargaining with Hospitals*, 28 J. HEALTH ECON. 350 (2009).

[30] Michael G. Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of 'Any-Willing-Provider' Regulations*, 20 J. HEALTH ECON. 955 (2001).

[31] Christine Piette Durrance, *The Impact of Pharmacy-Specific Any-Willing-Provider Legislation on Prescription Drug Expenditures*, 37 ATLANTIC ECON. J. 409 (2009).

[32] Jonathan Klick & Joshua D. Wright, T*he Effect of Any Willing Provider and Freedom of Choice Laws on Health Care Expenditures,* U. Penn. Inst. for Law & Econ. Res. Paper No. 12-39 (Feb. 24, 2014), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2183279.

[33] Proposed Rule, 79 Fed. Reg. at 1979.

[34] A literature review was conducted by FTC staff in preparing this comment has revealed no countervailing evidence. Our concerns about a failure to control for composition notwithstanding, CMS's own studies are generally consistent with the empirical literature, to the extent that CMS observes significant average savings associated with preferred pharmacies for 49/50 of the drugs they studied.

[35] *Id.* at 1979-80.

[36] Like CMS, we seek to avoid "policies that would be expected to interfere with competitive market negotiations," *id.* at 1969, and, absent anticompetitive conduct, the contract terms that are its result. In that regard, we also suggest that CMS might carefully study the potential costs of its proposed "T&C" disclosure terms. Consumers need accurate information on price and quality to make efficient purchasing decisions. For this reason, the FTC has challenged collusive attempts to suppress price information for consumers and has opposed government regulation that restricts advertising to consumers. Regarding attempts to suppress price information, *see, e.g.*, *Fair Allocation System, Inc.*, FTC Docket No. C-3832 (1998) (consent order) (challenging concerted action by auto dealers to restrict a competing dealer's ability to advertise over the Internet); *see also FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986) (challenging a dental association rule that prohibited dentists from submitting x-rays to dental insurers in connections with claims forms). Regarding over restrictive regulations, *see, e.g.*, *Massachusetts Bd. of Registration of Optometry*, 110 F.T.C. 549 (1988); FTC Staff Comments in the Matter of Request for Comments on Agency Draft Guidance Documents Regarding Consumer-Directed Promotion, Before the FDA, Docket No. 2004D-0042 (May 10, 2004), *available at* http://www.ftc.gov/os/2004/05/040512dtcdrugscomment.pdf. At the same time, there is no theoretical or empirical reason to assume that consumers require sellers' underlying cost information for markets to achieve competitive outcomes, and mandatory disclosures of such information can be costly, and can sometimes have the unintended consequence of publicizing proprietary business information in a way that could foster collusion among third parties.

[37] Proposed Rule, 79 Fed. Reg. at 1978.

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

# Congress of the United States

## House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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April 5, 2017

Dr. Janet Woodcock
Director
Center for Drug Evaluation and Research
Food and Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993

Dear Dr. Woodcock:

Thank you for appearing before the Subcommittee on Health on March 2, 2017, to testify at the hearing entitled "Examining FDA's Generic Drug and Biosimilar User Fee Programs."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on April 19, 2017. Your responses should be mailed to Jay Gulshen, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to jay.gulshen@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

**Attachment — Additional Questions for the Record**

**The Honorable Morgan Griffith**

1. Dr. Woodcock, I appreciate FDA's commitment to encouraging the development of abuse deterrent opioids. Manufacturers should be incorporating these technologies into their products and testing whether they do in fact deter the various routes of potential abuse (nasal, intravenous, etc.). If they do, they need to be able to include this data in their labeling and communicate this useful information to doctors.

   I understand that a recent decision by FDA calls into question whether multiple manufacturers in the same product class could make such claims, even if their data justifies it and even if they are using different technologies. Is that your understanding?

   a. Would you agree that such a position would discourage companies from investing in these technologies and run counter to FDA's commitment?

   b. If you think the statute requires this seemingly perverse outcome, can you please let us know so we can fix it?

2. What further actions will FDA take to transition the market to one in which patients receive abuse-deterrent opioids in the generic market?

3. I have heard that for product launch purposes, it is critical to generic manufacturers to have greater transparency and communication with FDA as their products get closer to approval. Are there reasons that FDA cannot communicate to companies when approvals are imminent and, if so, is there a way to address those issues or concerns?

4. How often and at what stages of the review process does FDA communicate with the applicant?

5. Are inspectional and compliance reviews communicated to the applicant? If not, what are the primary reasons for FDA not communicating the inspection and compliance status?

6. What type of feedback has the FDA received from applicants as to how helpful these communications are? From the applicants feedback received, what were the suggestions and recommendations made on how the FDA can improve communications?

**The Honorable Richard Hudson**

Dr. Woodcock, thank you for being here. I think you and I agree on the overall benefit of generic drugs have had for patients across the country. According to the Association for Accessible Medications, generics are 89% of the prescription drugs dispensed, but only 27% of the total drug costs. That is great for both drug cost and accessibility, which is great for patients. This user fee agreement represents a great opportunity for the FDA to shepherd more of these drugs through the approval process more efficiently and predictably.

Within the generic space, one thing that has been brought to my attention is the complex web of challenges companies face in bringing injectable generic drugs to market, making them particularly susceptible to shortages and price hikes.

1. What current flexibility does FDA have to prioritize the review of generic injectables?

2. How many and what generic drugs have you expedited/approved at FDA because only one generic drug is in the market?

3. If given the Secretary was given the authority under the Lower Drug Costs Through Competition Act to push priority applications through in 6 months, would this help alleviate the shortage of these critical drugs?

4. Should the secretary be given the authority to prioritize more than one injectable generic in some instances?

**The Honorable Gene Green**

As we know, most marketed over-the-counter (OTC) products are regulated through a system of ingredient-based monographs that was implemented in the 1970s. FDA has been able to make determinations about the general safety and efficacy of the active ingredients in thousands of OTC monograph drug products, providing consumers with access to products. However, the system is administratively challenging and flawed, and FDA is critically under-resourced in this area. Dr. Woodcock, I appreciate the work that FDA has undertaken with stakeholders to reform the OTC Monograph. Can you explain why you believe OTC Monograph reform is needed at this time, and what is the public benefit of OTC Monograph reform?

**The Honorable Frank Pallone, Jr.**

1. Priority Review

    a. The rising costs of prescription drugs continues to be an issue of immediate concern to patients and their families. The examples of Sovaldi, Daraprim, and EpiPen highlight the dramatic price increases that have been occurring in the prescription drug market, and also how the rising costs of prescription drugs is not limited to one sector of the market. One solution that has been presented to address the issue of rising drug costs has been the prioritization of the review of abbreviated new drug applications (ANDAs) as a way to bring competition to the marketplace. On average, the cost of a generic drug is 80 to 85 percent lower than the brand name product.

    b. FDA has taken steps to prioritize the review of certain generics through the agency's Manual of Policies and Procedures entitled, "Prioritization of the Review of Original ANDAs, Amendments, and Supplements". At the hearing, you indicated that first generics, shortage drugs, PEPFAR treatments, and others are prioritized under this policy. In comparison to a standard ANDA, what is the

average timeline for review for an ANDA prioritized under the MAPP? How many ANDAs have qualified for prioritization under the MAPP?

2. GDUFA Reporting

    a. Prior to GDUFA I, FDA publicly posted data regarding median approval times for generic applications. The current monthly activity reports no longer include this data. When this Committee was first discussing the creation of GDUFA, the median review time was 30 months. Unfortunately, rather than the median review time decreasing under GDUFA it has actually increased. My understanding is that the median review time in FY2015 was an estimated 48 months. Please provide the Committee with median approval data of ANDAs under GDUFA I. What steps is the agency taking now, and what steps will the agency take under GDUFA II, to bring the median approval time down? Will FDA commit to sharing median approval data for ANDAs publicly moving forward?

3. Complex Products

    a. One of the enhancements included in GDUFA II is a pre-ANDA program for certain complex products. This pre-ANDA program would allow for sponsors to meet with FDA prior to submitting an application to receive advice regarding their development program and their submission. I understand that the goal of this program is to help sponsors develop complete submissions and reduce the number of cycles to approval. Please explain this program further, and also explain why the GDUFA II agreement limited the pre-ANDA program to complex products.

4. Target Action Dates

    a. I understand that FDA has assigned Target Action Dates to all backlog and year one and year two applications. These target action dates were meant to help the agency prioritize its workload and to give sponsors a target date by which their applications would receive action. How are the target action dates being communicated to the generic drug application sponsors? Will these target action dates be maintained under GDUFA II?

5. Education for Biosimilars

    a. One of the keys to the adoption of biosimilars is ensuring that providers are adequately educated about the rigorous approval process they face. FDA regularly engages in provider education regarding its stringent product approval standards. Has the agency undertaken any education or outreach efforts on biosimilars? If so, what education efforts has the agency undertaken and what future education and outreach efforts are planned? Does the agency have sufficient staff and resources now to conduct these efforts?

6. Hiring Freeze

   a. On January 30, 2017, I wrote the Administration to express my concern regarding the impact the Presidential Memorandum issued on January 23, 2017, implementing an across-the-board hiring freeze, will have on the upcoming reauthorization of the FDA user fee programs. The memorandum outlines a federal hiring freeze applying to all federal civilian employees across the executive branch stating that the hiring freeze "applies to all executive departments and agencies regardless of the sources of their operational and programmatic funding." While guidance from the Office of Personnel Management indicates that some FDA personnel with the responsibility to work on public health safety "through programs such as food, drug, and medical device safety" may be exempt, it is still unclear how this hiring freeze will impact the recent user fee agreements in the areas of drugs, biologics, and medical devices. Is federal hiring utilizing private user fee revenues subject to the hiring freeze outlined in the memorandum? If so, please explain how the agency will be able to meet the negotiated performance goals of the user fee agreements? Is the hiring authority provided to FDA under the 21st Century Cures Act subject to the hiring freeze outlined in the memorandum? If so, please explain why.

7. H.R. 749

   a. The Committee is also considering H.R. 749, the Lowering Drug Costs through Competition Act. Among other things, this legislation would create new incentives to encourage competition from generic drugs through the prioritization of certain ANDAs and the establishment of a priority review voucher (PRV) program for generic drugs. As the Committee begins its work on this legislation, we would request formal technical assistance from the agency regarding how we can best achieve the goal of increased competition from generic drugs.

   b. In addition, we would request the agency's response to the following questions:

      i. H.R. 749 would create a priority review for ANDAs for drugs that have not been introduced by more than one manufacturer or have been on the drug shortage list. How would this interact with the prioritization under FDA's MAPP? Is this consistent with the priority review process agreed to under GDUFA II? Is a six month timeline achievable? Does FDA have sufficient resources currently to meet a six month priority review timeline?

      ii. H.R. 749 creates a new PRV program for generic drugs. Does FDA believe a new PRV program will be helpful for incentivizing new generics? Does FDA have the resources needed for establishing a fourth PRV program?

      iii. H.R. 749 includes language that would create a novelty requirement for tropical disease PRVs by requiring new clinical investigations. Will this language help to close the loophole of tropical disease PRVs being

awarded to companies who purchase a company for purposes of receiving a PRV? If not, how would we address this?

**The Honorable Markwayne Mullin**

1. The CEL-SCI Corporation, which has been put on a clinical hold by the FDA was recently granted a Type A meeting by the FDA. They have been on a partial clinical hold for 5 months, which jeopardizes their trial and their business. While we recognize that has 30 days for each response, given the length of the CEL-SCI Corporation partial clinical hold, that this is the largest ever Phase 3 study in head and neck cancer, and that there is an unmet medical need with Orphan Drug designation, is there not a way to accelerate the review of CEL-SCI's submissions? The longer the study is on clinical hold the harder it will be to complete, and the less likely a small company like CEL-SCI will even be around to complete it. We have seen in prior clinical holds that the FDA often reviews data more quickly than the 30 days given to its staff.

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

# Congress of the United States

## House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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April 5, 2017

Mr. Allan Coukell
Senior Director
Health Programs
The Pew Charitable Trusts
901 E Street, N.W.
Suite #10
Washington, DC 20004

Dear Mr. Coukell:

Thank you for appearing before the Subcommittee on Health on March 2, 2017, to testify at the hearing entitled "Examining FDA's Generic Drug and Biosimilar User Fee Programs."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

**Responses to Questions for the Record submitted to the**
**Committee on Energy and Commerce**
**Subcommittee on Health**
**United States House of Representatives**
**April 19, 2017**
**Allan Coukell, Senior Director of Health Programs**
**The Pew Charitable Trusts**

**The Honorable Morgan Griffith**

1. **I'm interested in learning about your perspective on issues related to transparency in the drug supply chain, given Pew's extensive research in this area. I'm trying to understand why my community pharmacies report that they are struggling to purchase drugs - particularly generic drugs. Can you identify ways that Congress can improve price transparency in the generic drug marketplace?**

   Drug pricing is complicated by the complex payment and supply chain for pharmaceuticals. This includes a range of financial transactions involving many entities, such as drug manufacturers, wholesalers, pharmacy benefit managers, pharmacies and others.[i] The details of these financial relationships are typically considered proprietary and thus not available to the public.

   Like some other supply chain entities, pharmacies are responsible for purchasing and selling prescription drugs. A pharmacy's cost to acquire a drug may be influenced by a number of factors, such as choice of wholesaler and prices set by manufacturers. Some pharmacies participate in Group Purchasing Organizations, in which pharmacies combine their purchasing power to negotiate discounted prices from wholesalers or manufacturers.[ii] Pharmacy benefit managers (PBMs) and insurers contract with pharmacies to fill prescriptions for plan beneficiaries, generating revenue for the pharmacies. These contracts outline how the insurers and PBMs are to reimburse the pharmacies and may include criteria for payment based on drug acquisition costs, dispensing fees or other factors.

2. **I agree with your testimony that we can improve drug pricing transparency by making policy changes affecting pharmacy benefit managers (PBMs). In your opinion, do PBMs play a role in driving up drug costs?**

   PBMs play a number of critical roles in the prescription drug marketplace, including developing formularies, contracting with pharmacies, processing prescription drug claims, and negotiating discounts and rebates with drug manufacturers. While list prices of brand drugs have risen significantly in recent years, these increases are partially offset by manufacturer price concessions,[iii] largely in the form of rebates negotiated by PBMs. However, it is not known what share of these rebates are ultimately passed on to the entities that fund prescription drug coverage, including employers and patients.

   Similarly, analyses by the Centers for Medicare & Medicaid Services have found that Direct and Indirect Remuneration (DIR)—compensation to Medicare Part D plans or their PBMs that occurs after the point-of-sale, including rebates—has increased

substantially in recent years.[iv] While these payments serve to moderate premium growth for Medicare beneficiaries and the federal government, they can also increase beneficiary cost sharing at the point-of-sale, which is often based on the list price of a drug. Increased DIR may also increase the financial liability of the federal government, which pays 80 percent of drug costs once beneficiaries reach the catastrophic phase of their Part D benefits. Nevertheless, Medicare notes that the net effect of these trends on costs to beneficiaries and the federal government are unclear.

3. **How do we bring greater transparency to the role of PBMs in the supply chain and ensure there are no conflicts of interest?**

   As discussed in our testimony, one way for prescription drug plan sponsors to better understand their costs is to bring greater transparency of the terminologies and definitions used in their contracts with PBMs, which can be extremely complex.

   Another area for consideration is to what extent health benefits consulting firms that advise employers on benefits contracting may have financial relationships with PBMs. This issue is not well studied.

4. **Do you believe that we can further improve transparency by focusing on other entities in the drug supply chain, such as wholesale distributors? If so, what types of changes are needed?**

   Some types of transparency, such as that around contract terminology and definitions, may enable stakeholders to better understand their costs, which may improve the efficiency of the drug supply and payment chain. However, some experts, including the Federal Trade Commission, have raised concerns that other types of transparency—such as requirements for competitors to disclose the prices they pay—may lead to increased costs for consumers.[v]

**The Honorable Frank Pallone, Jr.**

1. **Nearly three-quarters of the public think that the cost of prescription drugs is unreasonable and that includes voters on both sides of the aisle. With the cost of prescription drugs increasing faster than spending on any other health care item or service, our constituents expect Congress to take action to ensure that prescription drugs are affordable for those who need them. Recently, we've seen price increases on a variety of different drugs make headlines.**

   Increased prescription drug spending is primarily driven by new high-priced drugs and year-on-year price increases for older branded medications.[vi] While there have been large price spikes for a small number of generics in recent years, as a class generics serve to lower total drug spending.

2. **Pharmacy compounders have suggested that they could help alleviate pricing concerns by making compounded product of very expensive FDA approved drugs, for example,**

**Daraprim. As Congress considers various policy options to address high priced pharmaceuticals we need to consider the risks as well as potential benefits of the various policy approaches. Can you explain what the risks and benefits of this approach could be? What are other policy options Congress should consider as they look at this issue?**

Access to affordable prescription medications is a critical health care concern and cannot be separated from the importance of ensuring the safety and effectiveness of those medications. Proposals to permit compounding pharmacies and outsourcing facilities to compound copies of FDA-approved drugs to address price increases would circumvent the FDA approval process, which is essential to ensuring that drugs work as intended and that their benefits outweigh their risks.

Compounded products are not subject to the same rigorous safety and efficacy testing as FDA-approved drugs. For a drug product to earn FDA approval, it must undergo rigorous clinical trials to ensure that it is safe for use and effective. Extensive testing is initially conducted to ensure that the product can be used safely. When a drug is deemed safe enough for testing in humans, three phases of clinical trials, monitored by the FDA, are required to further demonstrate safety and effectiveness. Generic drugs must establish bioequivalence- that is testing to demonstrate that the new form can be absorbed in the body in the same way and results in the same drug concentration as the original product, and thus that it is safe and effective for use. Compounded products do not undergo these types of testing.

Allowing compounded drugs to be marketed as substitutes for FDA-approved products also undermines the drug-approval framework and creates a significant disincentive for pharmaceutical companies to invest in the clinical testing necessary to earn product approval. It is important that public policy continue to uphold this testing regime to help ensure that only those drugs that are safe and effective make it to patients.

Beyond the fact that compounded drugs are not subject to the FDA drug approval process, there are additional safety risks associated with expanding their use. FDA-approved drugs are produced in facilities that adhere to Current Good Manufacturing Practices (CGMP), the most robust quality standards in pharmaceutical manufacturing, to help ensure consistently safe products; compounded products are not made under these same quality standards.[vii] Finally, approved drugs are subject to post-marketing surveillance, wherein the FDA analyzes reports of adverse events associated with their use. This allows the agency to continually assess a drug's potential risks after it has been approved and, if unexpected concerns emerge, take mediating action such as modifying a drug's label or even removing it from the market. All of these protections help to ensure that the risks of approved drug products are known, and that they are outweighed by the therapeutic benefit to patients.

Addressing escalating prescription drug prices is critical as it affects both patient access to medications and overall health care costs. However, compounding products for the purpose of creating low-cost versions of FDA-approved drug products unnecessarily exposes patients to safety risks.[viii]

[i] Kaiser Health News, "Tracking Who Makes Money On A Brand-Name Drug," October 6, 2016, http://khn.org/news/tracking-who-makes-money-on-a-brand-name-drug/

[ii] Department of Health and Human Services Office of the Inspector General, "Review of the Relationship Between Medicare Part D Payments to Local, Community Pharmacies and the Pharmacies' Drug Acquisition Costs," 2008, https://oig.hhs.gov/oas/reports/region6/60700107.pdf

[iii] IMS Institute for Healthcare Informatics, "Medicines Use and Spending in the U.S.: A Review of 2015 and Outlook to 2020," April 2016, Available at: http://www.imshealth.com/en/thought-leadership/quintilesims-institute/reports/medicines-use-and-spending-in-the-us-a-review-of-2015-and-outlook-to-2020

[iv] Centers for Medicare & Medicaid Services, "Medicare Part D – Direct and Indirect Remuneration (DIR)," Available at: https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2017-fact-sheet-items/2017-01-19-2.html

[v] Federal Trade Commission, "Amendments to the Minnesota Government Data Practices Act Regarding Health Care Contract Data,"June 29, 2015, https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-amendments-minnesota-government-data-practices-act-regarding-health-care/150702minnhealthcare.pdf

[vi] The Pew Charitable Trusts, "What's Driving Increased Pharmaceutical Spending?" May 26, 2016, http://www.pewtrusts.org/en/research-and-analysis/analysis/2016/05/26/whats-driving-increased-pharmaceutical-spending

[vii] For more comparing the safety measures followed by pharmaceutical companies that manufacture drugs with those used by compounding pharmacies, see these publications: The Pew Charitable Trusts, Pharmaceutical Compounding: Quality Standards for Different Scales (July 2015), available at: http://www.pewtrusts.org/~/media/assets/2015/09/drugcompounding_infographic.pdf?la=en (accessed 10/06/16); Clinical IQ, Quality Standards for Large-Scale Compounding Facilities, available at: http://www.clinicaliq.com/wp-content/uploads/2015/06/clinicaliq_compounding-quality-standards.pdf (accessed 10/05/16).

[viii] "Compounding Is Not a Safe Solution to Rising Drug Prices", The Pew Charitable Trusts, September 28, 2016. http://www.pewtrusts.org/en/research-and-analysis/analysis/2016/09/28/compounding-is-not-a-safe-solution-to-rising-drug-prices

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

# Congress of the United States

## House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

April 5, 2017

Mr. David R. Gaugh
Senior Vice President for Sciences and Regulatory Affairs
Association for Accessible Medicines
777 Sixth Street, N.W.
Suite 510
Washington, DC 20001

Dear Mr. Gaugh:

Thank you for appearing before the Subcommittee on Health on March 2, 2017, to testify at the hearing entitled "Examining FDA's Generic Drug and Biosimilar User Fee Programs."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on April 19, 2017. Your responses should be mailed to Jay Gulshen, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to jay.gulshen@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

**Attachment — Additional Questions for the Record**

**The Honorable Billy Long**

Mr. Gaugh, the witness Mr. Coukell testified, "pharmacy benefits managers – the middlemen that insurers and employers pay to both administer prescription drug benefits and negotiate discounts from drug companies – play a crucial role, using their large sales volumes and their ability to create formularies to force drug companies to offer deep price concessions." It is my understanding that PBMs employ a number of methodologies to lower costs, including promotion of generic substitution. Do you have information on how much generic drugs save consumers?

**The Honorable Morgan Griffith**

Can you please describe how your products move through the drug supply chain and how many separate organizations along that path have the ability to mark up the price? Are all of those price increases included in the Average Manufacturer Price (AMP) that you report to the government?

**The Honorable Frank Pallone, Jr.**

1. First Cycle Review

    a. The review model instituted in PDUFA is the result of lessons learned over multiple authorizations of the program and a commitment from both FDA and industry to work towards a first cycle approval. PDUFA now enjoys an average 80 percent first cycle approval rate. One common criticism we have heard from FDA is the need to improve the quality of applications under GDUFA so as to also move this program towards a higher first cycle approval rate. Dr. Woodcock noted in her testimony that prior to GDUFA generic applications were approved in one review cycle less than one percent of the time, a rate that has increased to only nine percent under GDUFA I. While a nine percent first approval rate is an improvement, it is clear that much more work must be done to ensure more generics are approved in the first cycle. What steps are being taken under GDUFA II to move industry towards a first cycle review?

2. GDUFA Communication

    a. Timely and meaningful communication between FDA and sponsors is critical to ensuring that both parties have a clear understanding of the standards and expectations for review, as well as the actions needed to receive generic approval. Wow often and at what stages of the review and approval process does FDA communicate with applicants currently? What improvements to communication are being made under GDUFA II?

3. Drug Pricing

a. Generic drugs have proven to be a safe and affordable alternative to name brand drugs and account for the vast majority of prescription drugs dispensed in America today. It is estimated that generics cost 80-85 less than their brand name counterparts, and these reduced costs have produced tremendous savings for patients. In 2015 alone generic drugs saved American families $227 billion.

    i. Why are generic drug manufacturers able to enter the market at a lower price point than brand drugs and how does the entry of a generic drug help to reduce prices in the marketplace?

    ii. In order for these savings to be realized, it is critical that we ensure continued access to the market by generics. What are some of the potential barriers to generics entering the market and what are the ways these barriers should be addressed?

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

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April 5, 2017

Ms. Juliana Reed
Vice President of Government Affairs
Coherus BioSciences
333 Twin Dolphin Drive
Suite 600
Redwood City, CA 94065

Dear Ms. Reed:

Thank you for appearing before the Subcommittee on Health on March 2, 2017, to testify at the hearing entitled "Examining FDA's Generic Drug and Biosimilar User Fee Programs."

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Sincerely,

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Chairman
Subcommittee on Health

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**Attachment — Additional Questions for the Record**

**The Honorable Richard Hudson**

You mention in your testimony that biosimilars are each unique large molecule biologics, and unlike generic drugs are not replicas of their branded counterpart, though they have no clinically meaningful difference.

1. As this is such a nascent industry and pathway, can you describe the challenges faced by the biosimilar industry and the FDA in negating this user fee agreement?

2. Can you go into the potential that the current pipeline holds for patient outcomes due to greater accessibility?

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April 5, 2017

Mr. Bruce A. Leicher
Chair
The Biosimilars Council
777 Sixth Street, N.W.
Suite 510
Washington, DC 20001

Dear Mr. Leicher:

Thank you for appearing before the Subcommittee on Health on March 2, 2017, to testify at the hearing entitled "Examining FDA's Generic Drug and Biosimilar User Fee Programs."

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**Attachment — Additional Questions for the Record**

**The Honorable Frank Pallone, Jr.**

Drug Pricing

1. Biologics are an important breakthrough in the way we treat disease. Congress passed the Biologics Price Competition and Innovation Act (BPCIA) as part of the Affordable Care Act, with the goal of creating a faster approval pathway for biosimilar products –because, like generics, biosimilars have the potential to significantly reduce the cost of treatments for consumers. Studies have shown that biosimilars could create savings of anywhere from $44 – $250 billion over 10 years.

    a. How will biosimilars help to reduce the cost of treatments for consumers? Can you provide an example of reduced costs based on the biosimilars that have been approved?

    b. Since BsUFA I was enacted, only four biosimilars have been approved and I understand only two of them are on the market today. What are the barriers to biosimilar development? Are there steps Congress should take to encourage continued biosimilar development?

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Minority (202) 225-3641

April 5, 2017

Ms. Kay Holcombe
Senior Vice President for Science Policy
Biotechnology Innovation Organization
1201 Maryland Avenue, S.W.
Washington, DC 20024

Dear Ms. Holcombe:

Thank you for appearing before the Subcommittee on Health on March 2, 2017, to testify at the hearing entitled "Examining FDA's Generic Drug and Biosimilar User Fee Programs."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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**Attachment — Additional Questions for the Record**

**The Honorable Billy Long**

Ms. Holcombe, we heard testimony on Thursday, March 2nd, that drug spending is rising faster than the rest of health care spending and is driving up patient out-of-pocket costs and insurance premiums. Further, we heard that increases in drug spending are not an aberration of a specific year or timeframe, but what was called "a long-term trend." Do you agree with those statements? If not, will you please provide the Subcommittee with evidence to counter those claims?

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