NATIONAL ASSOCIATION OF Manufacturers

April 16, 2026

The Honorable Bill Cassidy, M.D.
Chair
Committee on Health, Education, Labor, and Pensions
United State Senate
Washington, DC 20510

The Honorable Bernie Sanders
Ranking Member
Committee on Health, Education, Labor, and Pensions
United State Senate
Washington, DC 20510

Re: "Making Medicines More Affordable: How Competition Can Lower Drug Prices"

Dear Chair Cassidy and Ranking Member Sanders,

On behalf of the National Association of Manufacturers (NAM) and the 13 million people who make things in America, thank you for holding today's Senate HELP Committee hearing titled, "Making Medicines More Affordable: How Competition Can Lower Drug Prices."

The NAM is the largest manufacturing association in the United States, representing small and large manufacturers in every industrial sector and in all 50 states. Manufacturers have a deep commitment to providing health benefits to their workers, even as rising health care costs remain a top challenge for the industry. These benefits are an effective tool to attract and retain employees and to maintain a healthy and productive workforce. Manufacturers know that keeping employees and their families healthy is the right thing to do for the workers who keep America and its economy strong. Seventy percent of manufacturers cited rising health care and insurance costs as their primary concern in the NAM's most recent Manufacturers' Outlook Survey.[1] Despite this challenge, 95% of manufacturing employees are eligible for health insurance benefits, 80% of whom participate, which underscores the urgent need for action to reduce health care costs for manufacturers and manufacturing workers alike.[2]

The NAM appreciates the Committee's focus on health care affordability. Manufacturers are committed to providing health insurance to their workers, but substantive reforms are needed to realign our health care system to put patients first and reduce costs for companies, workers, and their families, while ensuring patients have access to the medicines they need.

Manufacturers know that ensuring workers have access to safe and effective medications is essential to controlling long-term health care costs. As such, the NAM has long raised concerns with price controls on life-saving and life-changing innovations that could stifle the research and development (R&D) investment that produces cutting-edge cures and treatments. Biopharmaceutical manufacturers in the U.S. lead the world in research and production because our nation rewards risk taking, scientific rigor, and scale. Price controls, like most-favored nation (MFN) mandates, fail to value innovation, which creates uncertainty, reduces the number of available medications, and drives up avoidable health care spending. MFN pricing pegs U.S.

[1] National Association of Manufacturers, Q1 2026 Manufacturers' Outlook Survey (March 12, 2026). Available at https://nam.org/wp-content/uploads/securepdfs/2026/03/NAM_Q1_2026_Outlook_Write_Up.pdf.

[2] Kaiser Family Foundation, *2025 Employer Health Benefits Survey* (Oct. 22, 2025). Available at https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf

drug costs to the lowest prices in selected foreign countries, importing those countries' restrictive pricing structures that fail to properly value innovation and limit their citizens' access to new and improved medications.[3] Adopting MFN pricing broadly would create uncertainty for patients and impede biopharmaceutical innovation. Instead of importing price control mandates, manufacturers encourage policymakers to consider reforms elsewhere in the health care system that will reduce costs for patients without limiting their access to life-saving treatments.

Impact on Innovation

In addition to the value that pharmaceuticals deliver to patients, society, and the health care system, drug pricing also reflects the risks and costs inherent in drug innovation, including investments required to bring a product to market through rigorous regulatory processes. Innovation in the pharmaceutical sector is a complex, lengthy, and cost-intensive process. R&D investments in the U.S. drive breakthrough discoveries and the development and commercialization of new drugs and therapies for Americans.

In the drive for continual innovation, pharmaceutical companies make up the largest share of all private-sector R&D in the nation, accounting for 36.1% of spending at $146.1 billion in 2023.[4, 5] It typically takes approximately $2.3 billion and 10 to 15 years of research, clinical trials, and regulatory approval before a new drug can be brought to market.[6, 7] Further, just 12% of the investigational drugs that enter a phase I clinical trial are ultimately approved by the FDA, meaning the other 88% fail along the way[8]—to say nothing of the discoveries that never make it into clinical trials. This cycle of discovery and development makes biopharmaceutical manufacturers economic engines, accounting for $355 billion in value-added output to the U.S. economy in 2021 and supporting an additional 4.1 jobs for every person employed by a biopharmaceutical manufacturer.[9]

Importantly, pharmaceutical R&D efforts are tied to and bolstered by revenue for the manufacturers in the U.S. that are making these substantial investments. Reductions in revenue translate into reduced rates of innovative effort, which ultimately harms patients. The USC Schaeffer Center has estimated that for every 10% reduction in expected U.S. revenues, pharmaceutical innovation—such as clinical trial starts or new drug approvals—is expected to

---

[3] For additional information on the NAM's view on MFN, please see our response to USTR's request for comments regarding foreign nations freeloading on American-financed innovation: https://documents.nam.org/IEA/NAM%20USTR%20Drug%20Innovation%20Submission_Final%206.27.25.pdf

[4] U.S. Bureau of Economic Analysis, "Table 5.6.5. Private Fixed Investment in Intellectual Property Products by Type," U.S. Department of Commerce".

[5] National Association of Manufacturers, "Facts About Manufacturing".

[6] Derep, Maxime, N-Side, "What is the Average Time to Bring a Drug to Market in 2022?" 2022.

[7] Deloitte. "Seize the digital momentum: Measuring the return from pharmaceutical innovation 2022" (January 2023). Available at https://www2.deloitte.com/content/dam/Deloitte/uk/Documents/life-sciences-health-care/deloitte-uk-seize-digital-momentum-rd-roi-2022.pdf

[8] DiMasi, Joseph A., Grabowski, Henry G., and Hansen, Ronald W. "Innovation in the pharmaceutical industry: New estimates of R&D costs." J Health Econ. 2016; 47:20-33.

[9] National Association of Manufacturers. "Creating Cures, Saving Lives: The Urgency of Strengthening U.S. Pharmaceutical Manufacturing" (October 2023). Available at https://documents.nam.org/COMM/NAM-Creating%20Cures,%20Saving%20Lives_FINAL3.pdf

ultimately fall by 2.5% to 15%.[10] This reduction is significant to the patients who could lose out on new and improved therapies that may no longer be researched and developed due to lack of revenue to do so.

Concerns with Foreign Reference Pricing

Manufacturers are concerned with basing domestic drug costs on the costs paid by other countries. Many foreign countries have government policies that fail to properly value innovation, including clawback and other revenue return mechanisms. These countries restrict patient access to innovative medicines by refusing to cover certain treatments they deem too expensive, actively harming their citizens. Numerous countries either directly or indirectly rely on quality-adjusted life years (QALYs) in their pricing schemes. QALYs are a mechanism to assign value to new treatments, but because QALYs assign lower numerical values to disabled or elderly patients, they can be discriminatory towards vulnerable populations while ignoring other elements that may matter to patients and caregivers. The U.S. has traditionally rejected such discriminatory pricing methods. Congress has expressly prohibited CMS from using these discriminatory metrics in pricing discussions in existing statutes and manufacturers would be deeply concerned if QALYs were indirectly used to price pharmaceuticals domestically.

Instead of implementing domestic price controls that are tied to foreign markets that disincentivize innovation, the NAM encourages Congress to work with the Administration to secure non-discriminatory and fair market access terms through changes to market access policies in foreign markets, along with pursuing robust intellectual property rights that are adequately enforced. This would level the playing field and ensure that U.S. patients are not bearing an unfair burden of funding global innovation, while also ensuring innovation continues so Americans can access life-saving treatments and cures.

Manufacturers urge policymakers to reject MFN and other price control systems that would hinder the next generation of medicines from being discovered, developed, and made here in America—and delivered to American patients. Instead, manufacturers recommend the following domestic reforms to reduce health care costs, without instituting harmful price controls that lead to negative downstream effects:

- Rein in Pharmacy Benefit Managers: Pharmacy benefit managers (PBMs) are underregulated middlemen that contribute to skyrocketing health care costs through opaque and concerning business practices. With the NAM's strong support, Congress has already increased transparency into PBM business models and compensation structures, which will give manufacturers the necessary data to make informed decisions about the prescription drug benefits they offer to their employees. Congress also instituted 100% rebate pass-through in the commercial insurance market, ensuring that manufacturers will receive the savings they negotiated in their contracts. These reforms are critical steps toward reining in PBMs' outsized influence on health care costs, but more must be done. Manufacturers support delinking PBM compensation from drug list prices in the commercial market, which would reverse PBMs' perverse incentives to increase costs at the expense of employers and employees.

- Reform the 340B Program: The 340B program has rapidly and massively expanded beyond Congress's intent of providing lower cost medicines and expanding care for low-

[10] USC Schaeffer Center white paper, "The Elasticity of Pharmaceutical Innovation: How Much Does Revenue Drive New Drug Development?" Feb. 18, 2025.

income and underserved patients—it is currently the second largest federal health care program. As covered entities have taken advantage of the program to increase their profits, it has had the effect of driving up the cost of ESI. The 340B program allows covered entities to charge patients' insurance the full list price for drugs acquired at 340B prices, which results in patients and employers losing out on rebates and hospitals keeping the spread. The expansion of the 340B program was associated with approximately $23 billion in additional employer-based healthcare expenses in 2023, of which employees paid about $4.5 billion per year in added insurance premiums.[11] An IQVIA study also found that the 340B program increases drug costs for self-insured employers and their workers by 4.2% due to the lost manufacturer rebates on drugs purchased at the 340B price.[12] This corresponds to a $5.2 billion increase in health care costs for self-insured employers.[13] The April 2025 report published by the Committee on the operation of the 340B program identified key issues within the program that Congress must address. These include current fee structures, third party administrator behavior, sub-grantee eligibility, and the ways in which patients benefit from the program. Additional reforms, such as patient definition and child site eligibility, will also return the program to the intent with which Congress created it. Manufacturers are grateful for Committee leadership on this issue and look forward to supporting related legislation.

- Expand Health Savings Accounts (HSAs): HSAs are personal tax-free savings accounts that patients with High Deductible Health Plans (HDHPs) can use to pay for out-of-pocket medical costs. HSAs provide greater flexibility and control over health care and health care costs for manufacturing workers. HSA funds do not expire and are not impacted by a change in employment. In 2025 Congress broadened HSA eligibility to include individuals that are covered under a direct primary care service arrangement, which manufacturers supported. However, additional reforms, including an increase in contribution limits and greater eligibility, are needed to give more people access to HSAs and to empower them to be able to contribute more tax-free dollars for medical expenses.

- Increase Access to Telehealth: Telehealth has improved access to care while helping to reduce health care costs for manufacturers, manufacturing workers, and their families. Virtual visits are typically less costly than in-person appointments, and they are far less expensive than care delivered in urgent care settings or in emergency rooms. Telehealth helps manufacturing employees access care more efficiently, reducing time away from work and minimizing workplace disruption. This is particularly true for preventative care, which results in significant long-term productivity increases and cost decreases. In 2025, Congress permanently allowed patients with HDHPs to access telehealth care before reaching their deductible. Manufacturers support additional reforms to increase access to telehealth, including allowing providers to practice across state lines, to help manufacturers reduce premiums and overall health care costs for their businesses and their workers.

---

[11] National Pharmaceutical Council, The 340B Drug Purchasing Program and Commercial Insurance Premiums. Available at https://www.npcnow.org/sites/default/files/2025-05/340B%20and%20Employer%20Costs%20White%20Paper.pdf

[12] IQVIA, The Cost of the 340B Program Part 1: Self-Insured Employers. Available at https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-part-1-self-insured-employers

[13] Ibid.

- Codify Association Health Plans: Association Health Plans (AHPs) allow multiple employers to join together to offer employer-provided group health insurance plans, granting them the bargaining power of larger group plans to secure more affordable coverage and negotiate better rates. Additionally, insurance companies are mandated to spend a smaller percentage of premiums on overhead and profit for large group plans (including AHPs), but not for small group plans. Manufacturers support codification of AHPs under ERISA to provide small employers with greater access to affordable group health coverage.

- Improve Data Transparency and Accessibility: Administering high-quality, affordable health plans requires the collection and analysis of massive amounts of data, a task to which manufacturers dedicate significant resources. Thus, it is critical that employer plan sponsors have user-friendly access to their complete data to make informed choices about their plan's operations. Data gaps make it more difficult for employers to design the highest-quality plans for their workers and require permanent and comprehensive fixes. While health insurance claims data is valuable and readily available, manufacturers need access to complementary data in order to fully understand if outcomes and quality goals are being achieved. Comprehensive data would enable manufacturers to track and manage chronic conditions, and to measure if various programs emphasizing primary and preventive care are actually improving outcomes across the entire beneficiary population. Additionally, improved transparency, audit, and disclosure requirements between plan sponsors and vendors, if constructed in a way that does not add regulatory burdens for plan sponsors, can help make it easier for plan sponsors to fulfill their fiduciary requirements. Such transparency, specifically price transparency, benefits manufacturing employees' experience in the health care system and enables them to make more informed decisions about their care. Updates to the hospital and insurer pricing files mandated by the No Surprises Act and transparency measures included in the Consolidated Appropriations Act of 2021 will make data more usable by plan sponsors, which will put better data in the hands of beneficiaries.

- Strengthen the Employee Retirement Income Security Act of 1974 (ERISA): ERISA enables manufacturers to provide health insurance to their employees. The law allows manufacturers to provide uniform, yet tailored, benefits to workers across multiple states. However, the complexities and bureaucracy of the health care system create obstacles for manufacturers. These challenges can be addressed through improvements to the current public-private health care system. Employers have struggled with the lack of standardized definitions and methods for measuring quality. Manufacturers would welcome stronger public-private partnerships to address this issue. Additionally, allowance of e-delivery of disclosures would help ease regulatory burdens for manufacturers. ERISA requires that employer health plan sponsors provide certain disclosures to plan beneficiaries on a regular basis. Employers are required to provide these disclosures by paper mail and are not permitted to default to electronic delivery. In 2020, the Department of Labor (DOL) finalized a rule to allow employer-sponsored retirement plans to default disclosures to electronic delivery via email and secure online portals, while still requiring paper disclosure to any beneficiary without adequate internet access. The NAM supports allowing the option for plan sponsors to default to e-delivery for employer-sponsored health plans as well. Manufacturers respectfully encourage the Committee to require that DOL apply the existing retirement plan electronic delivery safe harbor to health plans via a notice-and-comment rulemaking process.

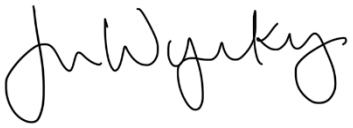
- Protect ERISA's Federal Preemption: ERISA's federal preemption of state and local laws and regulations is essential to the operation of ESI, as it allows multi-state employers to design and administer uniform benefits to all employees, regardless of the states in which they live. Eroding or eliminating preemption would force manufacturers to comply with a patchwork of cumbersome and potentially conflicting state-based rules, a costly and untenable situation.

- Protect the ESI Tax Exclusion: Employer contributions toward health coverage are tax deductible as a business expense, while employees' contributions are excluded from their taxable income. Altering this tax structure would substantially increase health care costs for both manufacturers and their workers by eliminating an important deduction and reducing take-home pay. Manufacturers strongly support maintaining the current tax treatment of health care benefits.

****

Manufacturers are increasingly concerned with the rising cost of health care, and our industry appreciates the Committee's continued consideration of solutions to address this critical issue. Please consider the NAM a resource and a partner as you work to implement these policy recommendations to ensure manufacturers can continue to offer health insurance to their workers, and their families, who work hard every day to power the American economy.

Sincerely,



Jess Wysocky
Director, Health Care Policy

Jake Kuhns
Vice President, Domestic Policy