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LEGISLATIVE PROPOSALS TO SUPPORT PATIENTS WITH RARE DISEASES

THURSDAY, FEBRUARY 29, 2024

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:02 a.m., in Room 2123, Rayburn House Office Building, Hon. Brett Guthrie [chairman of the subcommittee] presiding.

Present: Representatives Guthrie, Burgess, Latta, Griffith, Hudson, Carter, Dunn, Pence, Joyce, Harshbarger, Miller-Meeks, Obernolte, Rodgers (ex officio), Eshoo, Sarbanes, Cardenas, Ruiz, Dingell, Kuster, Kelly, Barragan, Blunt Rochester, Craig, Schrier, Trahan, and Pallone (ex officio).

Also Present: Representatives Schakowsky, and Matsui.

Staff Present: Kate Arey, Digital Director; Jolie Brochin, Clerk; Sarah Burke, Deputy Staff Director; Abigail Carroll, Detailee, FDA; Seth Gold, Professional Staff Member; Grace Graham, Chief Counsel; Sydney Greene, Director of Operations; Jay Gulshen, Senior Professional Staff Member; Rebecca Hagigh, Executive Assistant; Nate

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Hodson, Staff Director; Calvin Huggins, Staff Assistant; Tara Hupman, Chief Counsel; Sean Kelly, Press Secretary; Peter Kielty, General Counsel; Alex Khlopin, Staff Assistant; Karli Plucker, Director of Operations (WA-05); Emma Schultheis, Staff Assistant; Caitlin Wilson, Counsel; Lydia Abma, Minority Policy Analyst; Shana Beavin, Minority Professional Staff Member; Jacquelyn Bolen, Minority Health Counsel; Keegan Cardman, Minority Staff Assistant; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Tiffany Guarascio, Minority Staff Director; Stephen Holland, Minority Senior Health Counsel; Una Lee, Minority Chief Health Counsel; Gayle Mauser, Minority Health Adviser; Katarina Morgan, Minority Health Fellow; and Andrew Souvall, Minority Director of Communications, Outreach and Member Services.

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Mr. Guthrie. The subcommittee will come to order. The Chair will recognize himself for 5 minutes for an opening statement.

Thank you to our witnesses for being here today to discuss such an important topic. The legislation before us will take an important step in helping to sport rare disease patients. The Orphan Drug Act defines a rare disease as a disease that affects less than 200,000 patients across the United States.

According to the National Institutes of Health, NIH, there are over 10,000 diseases that fit this definition, impacting as many as 30 million Americans. Despite 10 percent of the U.S. population living with a rare disease, about 95 percent of these diseases lack treatments. Most patients can't even begin to think about treatments until they are diagnosed, which can be a long and costly journey, only to discover there are limited treatment options, if any.

Research and development into therapies designed to treat rare diseases is challenging, especially when it comes to measuring the safety and efficacy of drugs for smaller patient populations. Make investment in rare disease therapies risky and unpredictable.

Recognizing these hurdles Congress has taken numerous steps over the years to better support every stage along the drug approval pipeline, from supporting basic research to rare diseases to approving the process by which drugs seek and receive FDA approval for rare disease indications to ensuring that payers like Medicare and Medicaid will cover these treatments when they come to market.

For example, Congress authorized the pediatric rare disease priority review voucher program at FDA almost a decade ago to bolster existing incentives created under the Orphan Drug Act.

The priority review voucher reduces the financial risk for innovators to obtain resources needed to conduct critical rare disease research which ultimately helps patients success therapies or treatments more quickly. That is why we are authorizing the pediatric rare disease priority review voucher program. The Creating Hope Reauthorization Act is so important.

Since its inception. Almost 30 party revouchers have been granted that have paved the way for groundbreaking therapies that may otherwise not have made it to patients. I would like to thank my colleagues on the committee for their bipartisan work on this issue.

We are also considering bipartisan solutions to ensuring access to treatments for rare disease patients by promoting certainty and consistency throughout the regulatory and reimbursement process.

First we have Accelerating Kids Access to Care Act led by Representative Miller-Meeks which will streamline care for kids in Medicaid by making it easier for the them to receive necessary care by a provider in another State.

This is a concern for children who must travel out of State to centers of excellence to get the care they need for rare diseases.

We also are considering my discussion draft the Patient Access Act, which removes burdensome regulations to make it harder for patients to access lifesaving therapies. In some cases, patients and their families must travel significant distances to receive therapies that require lengthy stays, leaving the patient and their families responsible for hotels, food and other important expenses while they miss work or other obligations.

My bill would amend the statute by permitting manufacturers to pay for these

incidentals in very limited circumstances to make accessing these critical therapies easier for patients and their families.

Both bills will build off this committee's work in passing and Protecting Healthcare for All Patients Act to ban discriminatory barriers for those with disabilities to lifesaving healthcare services by passing my bill the MVP Act, which provides access to curative cell-and-gene therapies for Medicaid patients.

Finally, our efforts to increase access to lifesaving therapies we are considering every narrow statutory fixes which will help ensure patients maintain access to lifesaving affordable cures and treat rare diseases. The MINI Act PLASMA Act all make changes to the Inflation Reduction Act and provide innovators working in complex diseases with more runway as they invest in research in areas.

I hope we can have a constructive conversation today and set aside our broader disagreements disagreements regarding the IRA as to how these small policy fixes can have big impact for patients.

In closing, while none of these bills serve as a silver bullet to solving all the challenging problems faced by rare disease patients, they are important steps and will make meaningful difference in the lives of millions of Americans living with rare diseases.

Thank you. And I yield back.

I will now recognize the gentlelady from California, the ranking member chair Eshoo -- ranking member Eshoo for 5 minutes for an opening statement.

[The prepared statement of Mr. Guthrie follows:]

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Ms. Eshoo. Thank you, Mr. Chairman and good morning colleagues and all of our guests here in our hearing room.

Today, on Rare Disease Day we are considering several bills to help the 1 in 10 Americans living with a rare disease. Over the last 40 years there has been a revolution in the development of drugs to treat rare disease, also known as orphan drugs. FDA has approved more than 5,000 orphan drugs since passage of the Orphan Drug Act of 1983. Last year more than half of all new drugs approved by the FDA were orphan drugs, bringing hope to millions of Americans.

But there is room for improvement, only 5 percent of the more than 7,000 known rare diseases have an FDA approved treatment and clinical trials don't reflect the diversity of our Nation. Among the most neglected, our children. Few FDA approved treatments for rare diseases have been tested to be used in children. Children are not little adults.

Something Congress recognized 20 years ago when it passed my Best Pharmaceuticals for Children Act and my Pediatric Research Equity Act to reward and require pediatric studies. There is more Congress can do to ensure that children are not left behind. 36 percent of drugs approved for rare diseases relevant to children since 1999 lack some or all pediatric data.

The Innovation and Pediatric Drugs Act which I introduced with Representative McCaul will close the loopholes so that we have the clinical data we need to safely treat children with new cures. The American Academy of Pediatrics, the Leukemia & Lymphoma Society, the Children's Hospital Association, Stanford Medicine Children's Health, the Alliance for Childhood Cancer and the National Organization for Rare Disorders endorsed this bill. And I thank all of those organizations.

Children should also benefit from advancements in cancer treatments which is why Representative McCaul and I introduced the Give Kids a Chance Act. Currently the FDA cannot direct clinical trials to test combinations of drugs in children despite combination therapies proving effective in adults. Our legislation gives FDA that authority.

The legislation has 188 bipartisan cosponsors and has been endorsed by 50 organizations in research consortium. Every member of this committee voted for this legislation as part of the FDA user fee legislation last Congress.

Finally, I join Representatives McCaul, Burgess, Barragan, Bilirakis and Trahan in introducing the Creating Hope Reauthorization Act to incentivize research by providing pediatric drug developers with vouchers to speed FDA reviews of new drug products.

The pediatric priority review voucher program can make the difference between whether a drug comes to market or not. More than 114 organizations endorse this bill and the last time this legislation was up for reauthorization it passed the House unanimously by a voice vote. Highly instructive to all of us.

Our subcommittee's also considering three bills to undermine Medicare's historic new power to negotiate lower prices for drugs. Thanks to the new law Medicare beneficiaries are saving money through free vaccines, insulin capped at $35 a month and some beneficiaries out-of-pocket prescription drug costs capped at about $3,500 per year. Next year all beneficiaries will have their part D cost capped at $2,000 a year. There are bills before us today that unfortunately will weaken that process, they are also unneeded.

As we all know, Medicare drugs price negotiation is only focused on the top selling, high-cost Medicare drugs without any market competition. The bills before us

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today attempt to create unneeded loopholes to chip away at Medicare's power to negotiate and will raise costs for beneficiaries and taxpayers. I think they are ill advised and something I cannot support.

So I look forward to today's hearing, Mr. Chairman. Thank you for calling it and I yield back.

[The prepared statement of Ms. Eshoo follows:]

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Mr. Guthrie. Thank you, the gentlelady yields back. And the chair recognizes the chair of the full committee, Chair Rodgers for 5 minutes for an opening statement.

The Chair. Good morning, welcome everyone. I am pleased that we are gathered here today on Rare Disease Day to examine legislation to help move forward efforts to promote innovation for people with rare diseases. And make sure all patients can benefit from all the exciting innovation that is happening.

We are going to take action for patients, like Hunter Davis, a 12-year-old with spinal muscular atrophy type one whose mother Khrystal is here today. There is over 10,000 known rare diseases affecting an estimated 30 million Americans like Hunter. However, only about 500 of these diseases have FDA approved treatments. But now more than ever there is increasing hope with new genetically targeted technologies, cell and gene therapies and many more innovation being researched and development some of which we will hear about today.

We made progress on fostering innovation to find rare disease treatments. But there is still a lot of work to be done. Prior to the passage of the Orphan Drug Act, just over 40 years ago, only 38 orphan drugs were FDA approved. Compare that to 2023 alone when 40 novel orphan designated drugs and biologics were approved by the FDA, many of them potentially curative. Our job is to make sure FDA is ready and the market continues to foster innovation that leads to treatments and cures for patients.

I am concerned that if we don't continue to encourage investment in rare disease efforts, we will be harming the potential for the development of life changing treatments. Many of the bills before us today seek to provide the regulatory clarity necessary to ensure that novel therapies and in some cases cures continue to be accessible to patients as rapidly as possible.

As we work to carry out that mission we must carefully examine all the legislation before us today to ensure that it doesn't have the opposite effect and stifle innovation. Additionally, we need to make sure that once drugs are approved, patients can actually access them. One issue we will discuss today is how treatment options for certain diseases are often concentrated at or limited to centers of excellence.

In many instances access may come down to whether patients can afford to travel across the country or stay in a different city for weeks at a time to receive lifesaving care that they need.

Congressman Guthrie's draft Patient Access Act will help make these costs more manageable so that patients and in the case of a child, a parent can travel to get the care that they need by allowing for drug manufacturers to directly support patient's incidental costs of travel. Meanwhile, Congresswoman Miller-Meeks' Accelerating Kids Access to Care Act would cut red tape that restricts a pediatrician's ability to get paid by Medicaid to treat kids who are enrolled in a different State's Medicaid program.

There are also three bills we will discuss today to amend the Inflation Reduction Act's drug pricing scheme. While I recognize members of this committee have differing opinions on the best way to ensure Americans have assess to innovative lifesaving cures.

I hope that we can set aside some of those broader discussions and focus on what is best for rare disease patients. Because the process that led to the IRA's drug pricing scheme was so rushed I don't think everyone fully understood how some of the changes could have devastating impacts on the rare disease community.

Last Congress, after rejecting H.R. 3 with bipartisan opposition, this committee did not get the opportunity to explore the potential consequences of the IRA's new scheme. I am hopeful today we will do that work that this committee is known for and work in a

bipartisan way to address some of the consequences that have come to light since its passage. These three bipartisan bills before us today are a first step to doing so.

This committee has a long history of working together to support innovation, including things like the 21st Century Cures Act, multiple FDA user fee authorizations, and we must continue to build on this work. That is, exactly what we are doing today.

I look forward to learning more about what we can do from our witnesses and finding where the committee can move forward with bipartisan legislation to help families all across the country. I yield back.

[The prepared statement of The Chair follows:]

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Mr. Guthrie. Thank you. The chair yields back. And the chair will recognize the gentleman from New Jersey, the ranking member of the full committee Mr. Pallone for 5 minutes for an openings statement.

Mr. Pallone. Thank you, Mr. Chairman. For years this committee has worked to expand access to care and research and development of new treatments for rare diseases. And I am pleased we are continuing to work today by continuing considering those likely Accelerating Kids' Access to Care Act, the Innovation and Pediatric Drugs Act and the RARE Act.

However, it is unfortunate that we are also considering a number of proposals that will undermine policies to lower prescription drug prices that congressional Democrats and President Biden delivered for the American people as part of the Inflation Reduction Act.

I was proud to lead the effort on the drugs pricing reform measures that were ultimately included in the Inflation Reduction Act. Thanks to that law Medicare is finally going to be able to negotiate lower drug prices for America's seniors. Just a few weeks ago the Biden administration sent the first offers in drug price negotiations to the 10 drug manufacturers selected for negotiation during this first year.

About 9 million seniors take one or more of the drugs selected for negotiation at a cost to those seniors in 2022 of $3.4 billion. We can make a real difference by negotiating lower costs for these drugs.

Last year, thanks to the Inflation Reduction Act's penalty on drugs manufacturers who raise prices faster than the rate of inflation, seniors saved as much as $618 per average does on 47 drugs. And beginning next year prescription drug costs will be capped for seniors at $2,000 annually. But despite the fact that this law is already

making prescription drugs more affordable for our Nation's seniors, the pharmaceutical industry and congressional Republicans are relentlessly attempting to undermine it through lawsuits and detrimental policy changes that will only delay lower costs for patients.

Republicans claim that we must choose between lower prices and greater innovation. They argue that if we want innovative therapies it is up to American families to pay for high price drugs that wipe out their life savings, cost more than the average household's monthly rent or groceries and are priced two to three times higher than in other countries. And I reject that premise. I refuse to believe that innovation and lower cost are a zero sum gain. After all we know that patients need affordable access to new therapies, particularly those with a rare disease or condition.

And that is why I am disappointed we are discussing legislation that allows potential blockbuster drugs to be exempt from negotiation and delays negotiating other drugs for years. These bills are contrary to the intent of the law which was carefully drafted to protect innovation while also delivering savings.

And our intent in passing the Inflation and Reduction Act was to ensure that those drugs that represent the greatest share of cost to the Medicare program are negotiated on behalf of the American people. We have crafted a narrow exclusion for orphan drugs to treat one rare disease, but this was not intended to be an escape hatch for manufacturers to avoid negotiating fair prices game the system. Patients with rare diseases can only access treatments if they can afford them. And the Republican plan laid out today will keep these products out of reach for too many families.

And while I cannot support legislation that undermines the Inflation Reduction Act, I am pleased where examining bills from Ranking Member Eshoo and Ranking

Member Matsui on how we can incentivize additional development of rare disease treatments and ensure regulatory certainty for developers. However, it is important that we also consider whether existing programs are providing the incentives Congress intended. One of the bills before us today reauthorizes the Rare Pediatric Disease Priority Review Voucher Program at the Food and Drug Administration.

I am concerned about reports from the Government Accountability Office and others that suggest that vouchers fail to incentive research and development and instead use scarce public resources to reward development that would have taken place even without this program.

And I look forward to hearing what our witnesses have to say about these proposals. So I understand and appreciate the unique needs of the rare disease community and the hope that innovation and treatments can bring, especially for small populations of patients without other therapy options so I hope we can reject efforts to undermine the Inflation Reduction Act, which will likely cost the Federal Government billions of dollars and increase prices for consumers. Instead we should focus our attention on finding consensus approaches to bring more cures to patients.

With that, Mr. Chairman, I yield back the balance of my time.

[The prepared statement of Mr. Pallone follows:]

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Mr. Guthrie. The gentleman yields back. So that concludes all opening statements. You yield the balance of your time back, right? Okay, I didn't know if you were yielding to somebody else, sorry.

So that concludes all opening statements from members. We will now go to witnesses' opening statements so you guys will have 5 minutes to summarize your written testimony.

You will notice I think most of you -- some of you have testified before that there you will see a green light at 4 minutes, it will go to yellow so that means you will have a minute to wrap up. When it gets to red that means to wrap up and we will move to the next witness.

So I will introduce all the witnesses and then we will move it your statements.

So first we have Dr. Jeromie Ballreich, Ph.D. associate professor, Johns Hopkins Bloomberg School of Public Health. We have Terrence Flotte, M.D., provost and Dean of Umass Chan Medical School, Vice President of American Society for Gene and Cell Therapy. We have Dr. Alexander Bassuk. Is that correct.

Dr. Bassuk. Bassuk.

Mr. Guthrie. M.D., Ph.D., physician in chief university of Ohio Stead Family Children's Hospital, chair and professor, Stead family department of pediatrics. We have Dr. Aaron Kesselheim, M.D., J.D., MPH professor of Medicine Harvard Medical School, director, program on regulation therapeutics and law at Brigham and Women's Hospital. Professor Alice Chen, Ph.D, senior fellow, USC Schaeffer Center for Health Policy & Economics associate professor and vice Dean of research USC Sol Price School of Public Policy. And Ms. Khrystal Davis, J.D. a founding president of Texas Rare Alliance.

So I will now recognize Dr. Ballreich for 5 minutes for your opening statement.

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STATEMENTS OF DR. JEROMIE BALLREICH, PH.D. ASSOCIATE PROFESSOR, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH; TERRENCE FLOTTE, M.D., PROVOST AND DEAN, UMASS CHAN MEDICAL SCHOOL, VICE PRESIDENT OF AMERICAN SOCIETY FOR GENE AND CELL THERAPY; DR. ALEXANDER BASSUK, M.D., PH.D., PHYSICIAN IN CHIEF, UNIVERSITY OF OHIO STEAD FAMILY CHILDREN'S HOSPITAL, CHAIR AND PROFESSOR, STEAD FAMILY DEPARTMENT OF PEDIATRICS; DR. AARON KESSELHEIM, M.D., J.D., MPH PROFESSOR OF MEDICINE HARVARD MEDICAL SCHOOL, DIRECTOR, PROGRAM ON REGULATION THERAPEUTICS AND LAW AT BRIGHAM AND WOMEN'S HOSPITAL; PROFESSOR ALICE CHEN, PH.D, SENIOR FELLOW, USC SCHAEFFER CENTER FOR HEALTH POLICY & ECONOMICS, ASSOCIATE PROFESSOR AND VICE DEAN OF RESEARCH USC SOL PRICE SCHOOL OF PUBLIC POLICY; AND KHRYSTAL DAVIS, J.D., FOUNDING PRESIDENT OF TEXAS RARE ALLIANCE

STATEMENT OF DR. JEROMIE BALLREICH

Dr. Ballreich. Thank you. Thank you, Chairman Gutherie, Ranking Member Eshoo, and honorable members of the committee. Thank you for the opportunity to testify about legislative proposals for rare diseases.

I am an associate research professor focusing on U.S. pharmaceutical markets. The views expressed within my testimony do not necessarily represent the views of Johns Hopkins University.

I recognize the need to balance pharmaceutical access, affordability and innovation. This balance is particularly salient for pharmaceuticals to treat patients with

rare diseases. My objective for this testimony is to provide an overview of the current state of innovation in the rare disease space and rationale for maintaining the Inflation Reduction Act's price negotiation stipulations. In sum the following are my key points.

The IRA improves drug affordability. There has been little evidence that the IRA has significantly impacted pharmaceutical research and development. And we are benefiting from a tailwind of tremendous scientific breakthroughs for pharmaceuticals to treat rare diseases.

In the U.S. we have a drug affordability problem. One step to address this problem was the passage of the Inflation Reduction Act in 2022. The IRA improves prescription drugs affordability by lowering prices through Medicare price negotiation and inflation rebates and reduces out-of-pocket expenditures by instituting a $2,000 out-of-pocket max in Medicare part D. The biggest impact on pharmaceutical R&D from the IRA will be through price negotiations.

The CBO estimated price negotiations will reduce Medicare spending by $23 billion in the year 2030. While that is significant, it will represent less than 3 percent of U.S. pharmaceutical 2030 revenue. It becomes difficult to reconcile the doom and gloom rhetoric on innovation with a sub 3 percent impact on revenue. There will certainly be impacts but it is worth the trade off for improving drug affordability and access for Medicare beneficiaries.

Regarding rare diseases, I currently see no tangible evidence of the IRA impacting innovation. In 2023 there are 390 orphan drug designations and 90 orphan drug indication approvals in the U.S. These numbers were nearly identical to the 5-year average.

We have heard C suite executives mention the IRA may impact business decisions.

However, we have seen no R&D cuts on Big Pharma, we have seen a robust pharma merger and acquisition activity. And we have even heard recently a drug CEO say they were encouraged by initial price negotiations.

Lastly, rare diseases remain a focus therapeutic area for many biopharmaceutical companies. Some have speculated that bio 8 will cause companies to do delay seeking approval for rare diseases for drugs with large market approvals. This is particularly salient in oncology where drugs often receive multiple approvals over their lifecycle.

We certainly look at products launch strategies. However, I suspect they will still seek approval for rare diseases based on scientific plausibility and market potential. The reason being is that these supplementary approvals expand the market for these cancer drugs. Even when anticipating negotiating discounts, many cancer drugs will still have higher prices in the U.S. than Europe, suggesting a viable mark opportunity for companies to pursue.

We are subpoenaing a boon in gene therapies, thanks in part to the Orphan Drug Act, government funding and financing of the human genome project and a favorable risk reward profile for gene therapy development. The market is expected to increase by a fold, with many current and anticipated gene therapies coming to market with price tags in the hundreds of thousands of dollars. These therapies will treat patients with rare diseases and we need to ensure patients have access to these truly innovative medicines.

I encourage Congress to maintain the price negotiation provisions in the IRA to improve affordability and access. I also encourage Congress to support efforts by CMMI and public payers to develop innovative strategies to maintain a balance of affordability, access and incentives for innovation in the rare disease space. Thank you.

[The prepared statement of Dr. Ballreich follows:]

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Mr. Guthrie. Thank you. Thank you for your testimony.

The chair will now recognize Dr. Flotte. You have 5 minutes for your opening statement.

STATEMENT OF TERRENCE FLOTTE, M.D.

Dr. Flotte. Thank you, Chair Gutherie, Ranking Member Eshoo, and members of the subcommittee. I want to thank you for the opportunity to testify today on behalf of the American society of gene and cell therapy or ASGCT. My name is Terry Flotte, I am provost and Dean at Umass Chan Medical School, I am currently the vice president of ASGCT.

Our society is nonprofit professional membership organization of physicians, scientists, patient advocates and other professionals working together at universities, hospitals and biotechnology companies to expand the discovery and clinical application of gene and cell therapies for human disease.

My own life's work is rooted in being a pediatric physician scientist working in the rare disease space. There are over 10,000 rare diseases, up to 80 percent of which are single gene disorders. Gene therapy aims to address the underlying causes of disease.

Gene mutations, which as you know are mistakes in the basic blueprints of our body. Gene therapy can fill in missing parts or correct errors in those blueprints.

Early in my career doctors like me had few therapeutic options to offer these patients. Not being satisfied with this, in 1995 I led the first team of researchers to use adeno-associated virus or AAV as a vector or carrier in gene therapy trial for cystic fibrosis. AAV vectors are one of the basic building blocks of today's gene therapy

products. Vectors with the genetic information they carry can directly target the cause of disease and change the way a cell functions.

Gene therapies only to be administered one time to have a long lasting potentially curative effect. But of the thousands of rare diseases only a handful are being addressed currently with the products that are already licensed. And a smaller subset of the total number are being addressed with drugs in the pipelines.

The question now is how can we accelerate the path from gene to therapy and make these challenges easier to overcome when there is a limited medical and scientific capacity. Among the rare disease population around half affect children. That is why robust research is needed to help close the knowledge gap for these children. Gene and cell therapy offers a unique opportunity to address those research needs. Continued investment and basic translational and early clinical research on rare diseases is needed. ASGCT supports robust funding for the NIH to ensure that the U.S. remains a global leader.

Private sector investments have also played a critical role in the development of gene therapies. Maintaining a favorable investment and research environment created by the Orphan Drug Act and other programs is needed to continue growth and success in rare disease research. For example, gene therapy products represent more than a quarter of all designations in the pediatric priority review voucher program.

This incentive program uses market forces rather than government dollars to reward successful products as a win for product developers patients and taxpayers. We humbly encourage the committee to reauthorize it in a timely manner.

Cell and gene therapies often require specialized infrastructure, manufacturing administration facilities. These challenges can be mitigated by innovative trial

approaches such as decentralized trials -- decentralized studies in the use of real world evidence embracing innovative cellular designs can benefit patients in need. Our goal is to work collaboratively with FDA on these and others issues to create a regulatory framework that encourages and supports the development of available treatments. The society thanks this committee for its role in passing provisions in the last FDA user fee reauthorization that established the platform technology designation program as well as the advanced manufacturing designation program.

In closing, I want to express my thanks to the members of the committee for inviting me today to testify on behalf of the ASGCT. It is our view that since the human genome progress -- project, the progress achieved for patients in cell and gene therapy field is one of science's greatest achievements. Scientists and physicians have an obligation to do everything in their power to help patients and families living are rare genetic diseases.

Congress we must continue to robustly fund biomedical research in academia, support incentives for private sector investment and ensure that the FDA has appropriate review processes in place for expediting SEIF and effective cures for our most vulnerable disease patients. Thank you once again for the opportunity to address this important topic.

[The prepared statement of Dr. Flotte. Follows:]

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Mr. Guthrie. Thank you, Dr. Flotte.

The chair will now recognize Dr. Bassuk. You have 5 minutes for an opening statement.

STATEMENT OF DR. ALEXANDER BASSUK

Dr. Bassuk. Chair Gutherie and Ranking Member Eshoo, Chair McMorris-Rodgers and Ranking Member Pallone and distinguished members of the committee, thank you for the opportunity to participate in this hearing to discuss H.R. 4758, Accelerating Kids Access to Care Act.

The Accelerating Kids Access to Care Act has strong, bicameral support. And as an Iowaian I am proud that Congresswoman Miller-Meeks along with Congresswoman Trahan of Massachusetts of the House cosponsors of the legislation. This legislation will improve children's access to essential health care while eliminating administrative burdens for families, providers and States.

My name Alex Bassuk. I am a pediatric neurologist, physician scientist at the University of Iowa, department chair of pediatrics and the physician-in-chief of our University of Iowa Stead Family Children's Hospital. Our mission at the University of Iowa and Stead Family Children's Hospital is to improve the health of children through investigating new cures and treatments, teaching the next generation of pediatricians and pediatric scientists and providing excellent clinical care for children and their families. I am a member of the association of American Medical School Pediatric Department Chairs, the American Academy of Pediatrics and our hospital holds membership for the Children's Hospital Association. These organizations, along with countless others, have

been working tirelessly to support Accelerating Kids Access to Care Act.

Medicaid covers about one half of all children nationally and about one-third of the children cared for at the University of Iowa are covered by Medicaid. We are truly taking care of most vulnerable part of our population, children in poverty. Investing in children's health is not just the right thing to do it also pays off in the long term as we know that children who receive these services through Medicaid have better health as adults.

The university of Iowa Stead Family Children's Hospital is the only academic university associated children's hospital in the State of Iowa. The University of Iowa we have over 200 doctors who are solely dedicated to the care of children. In many cases our University of Iowa pediatric care doctors are the only specialists of their kind in the State and often the surrounding region.

And for children with rare diseases and complex medical conditions our University of Iowa pediatric doctors are usually the only doctors with any experience with those rare diseases. Because of this we sometimes have children with rare diseases for whom where the only place in the State, region and even the whole country with the knowledge to treat them and we do so with high quality and innovative care designed for children and their families to continue to thrive. For children outside of Iowa we may also be the closest medical center with expertise in a rare pediatric disease.

The bipartisan Accelerating Kids Access to Care Act would improve children's access to necessary out-of-state healthcare by streamlining the burdensome and time consuming Medicaid screening and enrollment process.

Today children on Medicaid needing care outside their home States often experience delays because some State Medicaid programs require out-of-state providers

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to be screened and enrolled into their program even if the provider is already enrolled and in good standing with their home State Medicaid program or Medicare.

As an example, Dr. Polly Ferguson, our division director of rheumatology is the world's expert for a rare and possibly fatal inflammatory bone condition called chronic recurrent multifocal osteomyelitis or CRMO. Children with this disease can have bone inflammation that is painful, deforming and they can even die from this disease.

Most doctors never seen see a single case of this rare disease. But if they do, because it is so rare they might miss the diagnosis. But Dr. Ferguson's work has helped uncover lifesaving treatment for this rare disease. Because of her expertise patients come to see Dr. Ferguson from all over the State of Iowa, all 50 States and even internationally.

But if a child with this condition is insured by an out-of-state Medicaid program evaluation and treatment by Dr. Ferguson could, depending on the State, require multiple levels of administrative approval, could be denied administratively and could be delayed because of other administrative burdens. These delays of weeks to months could potentially cause irrevocable harm to the child's health and future.

Sadly, we know of children with this rare disease who have already suffered the consequences of this administrative red tape when they could have been helped very quickly by Dr. Ferguson. I have given you an example where a child a rare disease and complex medical needs from outside of Iowa could be held by the bill under discussion, but of course the reciprocal is also true, there will be cases where children on Iowa Medicaid with rare diseases and complex medical needs might be greatly helped by receiving their care in an expedited fashion in another State. This bill is good for Iowa's children and good for children across the country.

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I urge this committee to act now and pass H.R. 4758, Accelerating Kids Access to Care Act. Thank you for the opportunity to testify before you today.

[The prepared statement of Dr. Bassuk follows:]

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Mr. Guthrie. Thank you, Dr. Bassuk.

The chair will now recognize Dr. Kesselheim for 5 minutes for your opening statement.

STATEMENT OF DR. AARON KESSELHEIM, MD, JD, MPH

Dr. Kesselheim. Chairman Gutherie, Ranking Member Eshoo, Chair Rodgers and Ranking Member Pallone and members of the committee, I am Aaron Kesselheim and I lead the program on regulation therapeutics and law at Harvard Med. Thank you for inviting me today to this special hearing on Rare Disease Day about various proposals covering the care of patients with rare diseases.

I want to highlight a few bills being debated and how they do and don't help such patients, to the ORPHAN Cures Act and MINI Acts, amend the Inflation Reduction Act which created a novel pathway for drug price negotiation by Medicare bringing it in line with all other goods and services Medicare covers. Negotiation of prescription drugs prices is important because rare disease patients, like all patients, pay far more for brand name drugs in the U.S. than comparable countries.

The IRA is designed to help Medicare reach a fair price that reflects the drug's clinical value. It covers drugs with $200 million a year in Medicare sales that have been on the market already 9 to 13 years. The IRA has numerous exclusions including drugs for a single rare disease. That exemption may have been included to ensure negotiators prioritized drugs that effect broader populations. But in reality, single rare disease drugs generate substantial revenue.

Among approved single rare disease drugs in the last decade we found that the

medial drug had earned $11 billion in global revenues in its first 9 years on the market, with Medicare spending on these products increasing from $3.4 billion in 2012 to $10 billion in 2021. In other research we have done, 5-year net sales on drugs for rare diseases were no different than drugs for more common diseases.

Thus in these cases developing drugs for rare diseases has been extremely lucrative for manufacturers, which is one reason why over half of new drugs approved by the FDA each year are rare disease drugs. Yet the ORPHAN Cures Act would expand the rare Medicare negotiation exemption to drugs approved for multiple rare diseases.

The median multiple rare disease drug in last decade had $746 million in peak annual Medicare expenditures, 35 percent higher than the median sole rare disease drug. There is no reason to exclude such blockbusters from a negotiation process that could help achieve a fair price, an increase rare disease patients access to the drugs they need.

The ORPHAN Cures Act also would delay negotiation on drugs that get a rare disease designation before being approved for a more common indication. But such drugs are among the most successful in Medicare, drugs like Keytruda, Opdivo and Urvoix (ph) to name a few and not one of them has a peak annual revenue below $2 billion a year. Instead of providing these drugs with a huge undeserved windfall, we should be encouraging firms to accelerate clinical development for secondary indications.

The MINI Act also included a negotiation delay. In this case, 9 to 13 years for so-called advanced drug products, a category it defines vaguely which could lead to valuable interpretation after enactment.

Would the exclusion cover a drugs like Ivacaftor, approved to treat a specific rare genetic mutation in subsets of patients with cystic fibrosis, this and one of its follow on products for another CF mutation was estimated to have a net present value of $33

billion a few years after their approval. No harm to innovation would come from the time we priced negotiate of such drugs.

Another bill up for discussion would renew the rare pediatric disease priority review voucher which is one policy ideas of last 2 decades, companies getting a rare pediatric disease drug approved can earn the voucher that accelerates FDA review of a non innovative costly drug by a few months. Innovative drugs already get priority review.

But our controlled studies have found that these vouchers do not help start new trials or bring new drugs to market in any field, much less rare pediatric diseases. And the FDA considers them disruptive to its review processes. There are far better ways to promote effective care for rare disease patients, including some of the bills being discussed today.

First, the RARE Act closes a court created loophole in the Orphan Drug Act and would help ensure that drugs for rare diseases faced competition in a timely fashion which can help lower prices and ensure a stable supply of rare disease drugs.

Second, the ALS Better Care Act would direct resources to paying for services for ALS patients and encourages engagement with clinical trials for new treatments for this important disease.

Third, the Innovation in Pediatric Drugs Act would generate more testing of rare disease drugs in children, which is often waived despite being required before approval and is deferred for years and years after the drug is already approved because there is no incentive or requirement on manufacturers to do these essential studies of these drugs in children.

And therefore, children will end up with rare diseases, will end up using drugs for

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years without sufficient guidance because drug companies delay these trials. Bills like these provide useful direct support for clinical care and essential research and will be most meaningful for patients with rare diseases. We should proceed with these efforts and avoid drug policy gimmicks like the priority review voucher or bills that undermine efforts to establish fair prices on blockbuster rare disease drugs.

Thank you very much.

[The prepared statement of Dr. Kesselheim follows:]

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Mr. Guthrie. Thank you for your testimony, Dr. Kesselheim.

Professor Chen, you are recognized for 5 minutes for your opening statement.

STATEMENT OF DR. ALICE CHEN, PHD

Dr. Chen. Thank you, Chairman Gutherie, Ranking Member Eshoo, and distinguished members of the committee. The opinions I offer today are my own and they do not represent the views of the University of Southern California or the USC Schaeffer Center.

Drug innovation has been crucial in addressing unmet patient needs. For rare diseases, treatment options are often limited and new drug developments can provide hope to patients and families facing challenging health conditions. Moreover, patients highly value these treatments. Our research at USC Schaeffer Center has demonstrated that while patients are generally sensitive to out-of-pocket costs, they are willing to pay higher prices for treatments of rare and complex diseases.

So to continue developing the types of innovations that patients value, manufacturers must expect positive returns on their drug development. This undertaking is challenging. On average, over 90 percent of drugs fail and of the small subset that do succeed it takes about 15 to -- 10 to 15 years from progress to initial discovery to progress from initial discovery to market approval.

This high risk of significant financial loss requires difficult trade offs. Drug manufacturers will typically be forced to pursue drugs with the greatest market potential as measured by the size of the target patient population and potential revenue streams of a specific drug.

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Due to the limited number of patients affected, rare diseases inherently present weaker financial incentives for drug innovation. That is why our society has created policies like the 1983 Orphan Drug Act to encourage rare disease drug developments.

Research has shown that 98 percent of the innovations stimulated by the Orphan Drug Act would not have occurred in absence of the policy. However, orphan drugs also tend to be some of the most expensive drugs on the market. So to strike a balance between ensuring affordability and nurturing ongoing pharmaceutical innovation, prices of new drug treatments need to match the value they deliver.

A value based pricing approach ensures that manufacturers are not only encouraged to create high value therapies but also discouraged from pursuing less beneficial drugs.

Three principals should guide pricing policies as it relates to rare disease. Prize should reflect value which should be comprehensively assessed based on the benefits patients and their families prefer.

Second, value assessment should be based on strong evidence measured not only through randomized clinical trials, but also through the ongoing collection of real world evidence.

Third, continued research should be rewarded beyond a drug's primary indication. This last point is particularly salient for orphan drugs, under the IRA drugs with an orphan designation as their sole FDA approved indication are exempt from future drug price negotiations.

But the IRA does not extend its exemption to drugs with multiple rare indications. This diminishes the incentive manufacturers have for exploring potential alternative uses for existing drugs in treating other rare diseases. Follow on indications are a critical

pathway for more cost effective innovation, especially in the realm of rare diseases where the limited sizes of patient markets can strain revenues.

Consider the fact that the average 5-year revenues for orphan drugs are 40 percent lower than they are for non orphan drugs. Moreover, ultra rare diseases with truly lows prevalence lack viable R&D incentives without other supporting mechanisms.

It is conceivable that this complication brought on by the IRA can be addressed through policy improvements like the ORPHAN Cures Act that could reinforce our society's desire to protect the interest of patients suffering from rare diseases.

While lowering pharmaceutical prices may seem at first like a logical approach in improving accessibility, this comes with a significant tradeoff, they diminish future drug innovation. Blunt price controls are not the answer because they are counterproductive from the perspective of improving patient health.

Instead, ensuring access to cutting edge treatments among rare diseases necessitates the exploration of innovative financing mechanisms, such as subscription based payment models or purchases that amortize the cost insurers paid for a lifesaving new treatment based on drug effectiveness, these types of solutions will create a more sustainable system that prioritizes patient access while simultaneously fostering valuable innovation for patients.

Thank you for the opportunity to testify today. And I look forward to answering any questions you may have.

[The prepared statement of Dr. Chen follows:]

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Mr. Guthrie. Thank you for your testimony.

And the chair now recognizes Ms. Davis for 5 minutes for your opening statement.

STATEMENT OF KHRYSTAL DAVIS, JD

Ms. Davis. Chair Gutherie, Ranking Member Eshoo, Chairwoman McMorris-Rodgers Ranking Member Pallone and distinguished members I thank you for the opportunity to testify on this Rare Disease Day.

I am a widow who recently lost her husband to glioblastoma, a rare brain cancer. I am rare disease parent and I am rare disease patient advocate. Our rare disease community includes one in 10 Americans affected by more than 10,000 rare diseases and 95 percent of rare diseases lack an approved treatment. At the current pace it will take thousands of years to secure treatments for all rare diseases.

Meanwhile, one-third of children with rare diseases will not survive to their fifth birthday. It is crucial we foster research and development of additional rare disease treatments and that rare disease patients can access their treatments upon approval.

I joined the rare disease community in 2011 when doctors diagnosed our newborn son, Hunter, with SMA. Our world forever changed. SMA is like ALS in babies, it robs the ability to move, swallow and ultimately breathe.

And at the time was the number one genetic cause of death for infants in the U.S. Doctors told us there was no treatment and no hope, but we couldn't afford to listen, the stakes were too high.

With the help of a researcher we manufactured a compound in the U.S. and took it to Mexico for a trial. 8 weeks after his diagnosis, Hunter was the first SMA patients to

receive a disease modifying treatment and that saved his life. SMA has three FDA approved treatments and every State screams newborns for SMA, our SMA community in the U.S. has largely achieved what we want for the greater rare disease community, pre-symptomatic diagnosis and treatment.

Hunter's SMA diagnosis would not be the only devastating rare diagnosis for our family. In June of 2022 my husband Curtis was diagnosed with glioblastoma, a lethal rare brain cancer. We knew Curtis' glioblastoma was a death sentence. Yet we still held out hope that we could secure another medical miracle; as we had for Hunter.

Sadly, this time science and luck would not be on our side. Glioblastoma falls squarely within the 95 percent of rare conditions lacking a disease modifying treatment. Curtis fought fiercely and courageously, despite having the porous biomarkers his tumor invading his motor strip and being on high dose steroids, Curtis was in the 25 percent of glioblastoma patients who survived more than 1 year. This is because Curtis had access to innovative treatments that slowed the progression of his glioblastoma for some time.

These innovative treatments allowed us to spend more time and make more cherished memories with Curtis. Curtis died on June 14 at the age of 54. I was by his side when he died and I watched him take his final breath. I lost my husband, partner in adventure and amazing father to our five children. He was an exceptional partner in all aspects of our relationship, including his partnership in being a caregiver for Hunter.

Although glioblastoma is a rare cancer it has claimed well respected and loved persons by those here in our Nation's Capitol Senator Ted Kennedy, Beau Biden and Senator John McCain. Congress recognized the unmet need for rare disease treatments and the additional barriers to orphan drug development born out of the small patient population and passed the Orphan Drug Act in 1983.

ODA incentivizes the development of orphan drugs for rare diseases. Unfortunately, orphan drugs with more than one indication become eligible for price negotiation under the IRA. This provision undermines the ODA and jeopardizes continued research, development and funding of orphan drugs that our rare disease communities so desperately need.

Yesterday ARPA H announced a $48.3 million award to every cure to develop an AI driven platform to revolutionize the future of drug development and drug repurposing. It is much easier to leverage existing orphan drugs for additional rare indications than to develop novel drugs.

However, the IRA significantly threatens the likelihood that orphan drugs identified as candidates to treat another rare indication would reach the rare disease patients they could help. The ORPHAN Cures Act encourages repurposing orphan drugs by exempting them from Medicare drug price negotiation so long as they only treat rare conditions. This is a fix that our rare disease community needs.

Thank you.

[The prepared statement of Ms. Davis follows:]

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Mr. Guthrie. Thank you for your testimony. Thank you for being here and being an advocate. We appreciate you being here. So that concludes all of our opening statements and we will now move to members questions. And I will recognize myself for 5 minutes to begin the questioning period.

And we talked about we heard some testimony on pediatric priority review vouchers, I know accelerated approvals moving forward. All of us have and there are advocates here in the audience today, have people come to our office and talk about access to drugs and access to -- they are against time, bumping against time.

And so we support it and we have to remember that it may only advance a few months, but a few months can be all the difference in the world. I have had a constituent with a child with muscular dystrophy. If I could just -- they can't reverse the damage that the disease does to them, but if they could stop it, they could stop it where they are so time does matter and so that is important for us. We can't dismiss that in an academic kind of way.

So professor Chen, we are talking about I kept hearing the term negotiation but it is really price control, Congress uses the power to tax in order to set up price controls. I know everybody here either has a Ph.D., J.D. or M.D. and I have neither, but I do have public school high school economics. And price controls always bring -- I know you can have elaborate systems to prevent it, but always brings you the lower quality or shortages.

And so would you -- we talked about Europe and what Europe pays. And it is frustrating that there are a lot of free riders on the American taxpayer for the paying for innovation and the research in drugs, but if we don't pay for it we wouldn't get it. And so what I will say is you can't get what Europe pays without getting what Europe gets.

So would you talk about the European model of price control limit they have to lifesaving drugs.

Dr. Chen. Sure Schaeffer Center research my colleagues have shown that if we adopt European price controls in the United States the outcomes is lower life expectancy. And the reason for this is because price controls limit incentives for innovation in the U.S. without price controls we see access to new innovation quicker and we see also more new innovation which improves the lives of patients.

Mr. Guthrie. Well, thank you. I want to kind of move to Dr. Bassuk. You talked about Dr. Miller-Meeks's bill. I live in Bowling Green, Kentucky, it is like an hour from Nashville. So people in my area, although they are living in Kentucky a lot of them use Vanderbilt, a world class center. You can be in northern Kentucky and be 10 minutes from Cincinnati general. And the wonderful people from southern Indiana use our wonderful facilities in Louisville. And so State lines sometimes become a barrier when you have Medicaid so that is you talked about it.

Ms. Davis, I have a bill to help people pay for expenses, also they have to travel. Would you talk about how expenses so I have ability for some manufacturers assist with lodging, travel, meals, how that can be a barrier for people to come even it on have access to the care.

Dr. Bassuk. Happy to answer. I think we definitely appreciate the goal of that particular bill. Anything that supports care coordination and any aspect of care outside of a child's State.

We are interested in exploring those policies that will alleviate the burdens for children and families in order for them to get the highest quality care. And it really is a burden for some of these really lifesaving, life altering -- as you heard from Ms. Davis

spectacularly changing the way kids' lives, kids who before the kind of treatment Ms. Davis was talking about would never sit up, never talk, never eat on their on their own.

These kids now can walk and talk and it is really amazing. But for some of these treatments and Dr. Flotte can discuss it even more, kids have to be a month in the hospital, they have to be under very close supervision because they have an extreme reaction that needs to be taken care of. And if they live in a State like mine, if they are very far from an academic center they are going to need some support so anything that we can do to support that is great.

Mr. Guthrie. We are looking to have access close enough to drive. But it gets to the other bill that you talked about it is across State lines. Like I said, Indiana is coming to Kentucky for great healthcare as well.

So Ms. Davis, you talk about your experience. I know what you had to do, I understanding you had to have a bus in order to travel to make sure you could get to the places you need to go and just the expense of what you had to go through as a family.

Ms. Davis. Yeah our family is very fortunate that we do have the expenses that we were able to bear that on our own, but that is not the case for many families in the rare disease community. And they need access to airfare, other travel, hotel accommodations. When they are traveling with children you have to remember they are also having parents that are missing work so they can go with the children to these treatments so they are hitting a lot of additional expenses for the families.

Mr. Guthrie. Well, thank you. I appreciate your testimony all of you being here today. My time is expiring. So I will yield back and I will recognize the ranking member Ms. Eshoo for 5 minutes for questions.

Ms. Eshoo. Thank you, Mr. Chairman.

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In listening to each of you I have to say this, a blessing to our country that we have, you know, such experts that have devoted their lives to bring that expertise for the betterment of humankind. So bravo to each one you. I am deeply moved by what you do and your testimony today.

Dr. Chen, I want to take exception to part of your testimony. I don't have a question, but to leave the impression with the Federal poverty line for a family of four in our country at $31,200 that you would reject affordability for drugs in our country, really just can't stand -- I mean, I -- I just reject it out of hand anyone with a child that has a rare disease would want to bring every last thing from themselves, their extended family and friends to help that child, but to reject, you know, affordability when some drugs are hundreds of thousands of dollars, I wouldn't be able to afford that and I have a pretty good job. And I don't think I would either on your salary.

So the affordability of drugs in this country is an essential policy in my view. And we can innovate and we can bring the prices down as well. And anything that stands in the way of that, I have to say I think does not serve the American people well. And it's the Congress that has to put that policy in place. It's the Congress and after what, 75 years we finally got to do it. And bravo to those who voted for it.

Dr. Crystal McCaul is one of the constituents. She is also a leading cancer researcher at the Stanford University that I have the privilege of representing and a former chief of the pediatric oncology branch the National Cancer Institute. She said the following about the FDA's rare pediatric disease voucher program which might Creating Hope Reauthorization Act would extend for 4 years.

"Before the program, I used to go with my hat in hand to beg investors to consider a potential drug. Now people take a second look and are interested in developing

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drugs. For example Novartis CD19 card known as KYMRIAH, the first cell based gene therapy approved the United States was approved in children first. That would have never happened without the voucher program." That is quite a compliment. So doctor -- is it Flotte?

Dr. Flotte. Flotte. Yes.

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[11:01 a.m.]

Ms. Eshoo. Well, I mean, this is -- I know the answer, but I want it for the record. Have children benefited from drugs made possible by the Rare Pediatric Disease Voucher Program, drugs like Kymriah?

Dr. Flotte. Well, in my opinion, Congressman, they certainly have. And I just want to describe the phenomenon in private sector investment in gene therapy. Much of it has been in the high-risk biotech sector, later to transition to Pharma, and many of the investors in that sector are looking at time. They are looking for a quick -- a relatively quick return.

Now, you can argue whether they should be doing that or not, but the fact is that with the discouraged -- some of the discouraging news in other markets, since 2021, over 50 rare diseases have had their clinical programs in gene therapy abandoned. There was a article came out this month in Human Gene Therapy, which I am happy to share with the committee, that describes each one of those -- one of those programs that was stopped.

We are at the mercy and families of patients with rare disease are at the mercy of the investment community to some extent for these highly innovative treatments that are really going to come out of the small biotech companies.

Ms. Eshoo. I represent many of those small biotech companies. Of the more than 7,000 rare diseases, 70 percent are rare genetic conditions present from the time a child is born, which I believe Ms. Davis spoke to.

How can we ensure that children aren't left out of the new frontier in cell and gene therapy?

Oh, I am over my time. We can take that for the record.

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Dr. Flotte. I didn't know if you were speaking to me or --

Ms. Eshoo. Thank you. Thank you, everyone. We appreciate you.

I yield back.

Mr. Guthrie. Thank you. The gentlelady yields back and the chair recognizes the chair, Chair Rodgers, for 5 minutes for questions.

The Chair. Thank you, Mr. Chairman.

Professor Chen, I just wanted to give you the opportunity to respond to some of the statements around the affordability of drugs and if you had any insights you would like to add.

Dr. Chen. Absolutely. Let me be clear, affordability is very important. This is why we have insurance. Insurance was designed to give patients financial protection in the case of rare and catastrophic events.

The price of a drug needs to match the value in order to continue to incentivize innovation that is valuable, and then we need insurance policies to be able to cover the valuable treatments that patients need.

The Chair. Thank you. I would also like to ask, because last year we had the debate -- last Congress. Last Congress we had the debate around H.R. 3. We have had continued hearings on the IRA. We have heard that true rare disease drugs are not at risk, only big blockbuster drugs.

Today we have some witnesses suggesting that the evidence is in, and we already know that the IRA isn't significantly impacting the development of rare disease treatments.

Professor Chen, how would you respond to those claims?

Dr. Chen. Well, I don't think we have enough evidence yet. My own research,

along with others, my colleagues, have shown that when you look at the Medicare Part D Act that was introduced in 2003, we didn't see any changes in innovation through the market-size expansion until 2006. The price negotiations in the IRA have not actually been -- come to fruition yet, so we need to wait and see.

The Chair. Thank you. A few of the bills before us would expand the FDA's authority to require drug companies seeking approval for an adult cancer drug or orphan drug to do studies in pediatric populations as well.

If a company were to comply with these mandates and end up getting approval for both the adult orphan indication and also the pediatric indication, would that trigger price caps?

Dr. Chen. So I am not an expert in the implementation of the IRA. But as I understand it, only drugs with a sole indication for a rare disease is exempt. So to the extent that those two categories are considered as two different rare disease indications, then that would trigger price negotiation.

The Chair. Thank you.

Ms. Davis, I want to -- well, first, I am very saddened to hear about your husband and the passing of your husband, and thank you for being here today, your strong advocacy. Certainly, we are hearing from colleagues across -- my colleagues across the aisle, their belief in the IRA and the provisions that were put into place.

I just wanted to ask you to give your insights as far as if you believe there are small things that need to be changed for the rare disease community?

Ms. Davis. Yes, absolutely. When you are a member of this community, you see firsthand the struggles of research and development, recruiting patients for clinical trials. All of these are much more burdensome for the rare disease community and they

are much more costly.

That is why we have the ODA. And, unfortunately, the IRA negatively impacts the efficacy of the ODA in driving the innovative research and development that the rare disease community needs to help ensure that we bring treatments for the 95 percent of rare diseases that lack in approved treatment.

The Chair. Thank you.

Dr. Flotte, it is exciting to see recent advancements in cell and gene therapies for rare disease patients. What are you most excited about over the next 5 years, and are those innovations mostly small molecule or biological products?

Dr. Flotte. So we -- ASGCT, of course, represents scientists who are pushing back the boundaries of frontiers of research on both oligonucleotides, which are classified as small molecules, and on gene and cell therapies.

The thing I am most excited about is to see the further clinical dissemination of gene editing technology, CRISPR technology, for the treatment of human diseases in somatic cells and affected organs in diseases.

The Chair. Thank you. In your testimony, you reference your experiences working with industry partners on clinical trials, some of which have failed for either scientific reasons or funding challenges.

What is your sense of why funding challenges take place? How do you, as an investigator, respond when disruptions occur, and do you sense there is a risk to some of the exciting innovation that you have discussed?

Dr. Flotte. Yeah, I do, since there is a risk. As I mentioned, there have recently been a number of clinical gene therapy programs that have been discontinued. The advancement of these therapies requires participation from NIH, from private industry,

from disease foundations, from universities as well. So when one of those parts falls out, it is very difficult to continue some of these programs.

And as the chair said, for the families, the clock is ticking for their children if the diseases progress, of which most of them are.

The Chair. Thank you.

Well, just let me also say thank you, everyone, for being here, the witnesses. We appreciate your insights. We are all committed. It is an exciting time when you think about innovation, but we need to make sure that we have access and affordability. And that is the goal today, especially as it relates to those with rare diseases. So thank you very much.

I yield back.

Mr. Guthrie. Thank you. Chair Rodgers yields back.

The chair recognizes Mr. Sarbanes for 5 minutes for questions.

Mr. Sarbanes. Thanks, Mr. Chairman. I would like to start by yielding 1 minute to Representative Schakowsky.

Ms. Schakowsky. Well, thank you so much for 1 minute.

I am so grateful that the legislation that I have introduced, the Alzheimer's Care Act, to improve the help for people with Alzheimer's disease. And what I really am happy about is what it does is that it has multidisciplinary clinics for Alzheimer's disease patients.

And I just wanted to ask Dr. Kesselheim, why would this kind of clinic be more helpful than what is available right now? It seems to me it would more focus on the 30,000-plus people in the United States that do have Alzheimer's disease.

Dr. Kesselheim. I mean, I think that the multidisciplinary care, the kind you are

talking about, would be really important for patients with Alzheimer's disease who require care from a number of different disciplines: medical doctors, respiratory therapists, physical therapists. And so I think that the kind of -- the bill that you are talking about which would help enhance and coordinate that care would be extremely important in providing the necessary care that patients with ALS need.

Ms. Schakowsky. Because Alzheimer's is fairly complicated, right, so you need these -- this multidisciplinary group to be there?

Dr. Kesselheim. And I think the most important -- another important part of your bill is that it encourages the enrollment in clinical trials, which, again, is the real way that we, you know, move science forward in trying to figure out what products actually work for patients with ALS.

Ms. Schakowsky. Okay. Thank you so much.

And I yield back.

And thank you, Mr. Sarbanes, for yielding.

Mr. Sarbanes. My pleasure.

I appreciate today's discussion about how we incentivize research, development for therapies and cures for rare disease populations, and the testimony here today has been very powerful.

I know we have had a discussion about whether the Inflation Reduction Act's policies to rein in the high cost of prescription drugs may be harming these types of investments, but I don't think the data, from what I understand, supports that assertion. Instead, it tells a different story, actually.

And I would like to enter into, without objection, Mr. Chairman, into the record a written statement from David Mitchell, the founder of Patients For Affordable Drugs.

Mr. Guthrie. We have documents listed in the -- we will act on it then.

Mr. Sarbanes. Okay. Thank you.

And he notes that companies have actually reported increased investments in research and development as this landmark legislation was emerging on the horizon and even in the wake of its passage.

For example, in 2022, Johnson & Johnson reported an 11.8 percent increase in R&D spending; Merck, an 11 percent increase; Moderna, a 65 percent increase, with further increases projected in 2023. And CBO has also found that there is been a consistent and continuous increase in capital investment.

Dr. Ballreich, does your research similarly indicate that the Inflation Reduction Act has not, in fact, disincentivized investment in new and innovative therapies and cures and has continued to provide incentives, actually, for such investment?

Dr. Ballreich. Yes. We actually have not seen any tangible evidence that companies have cut their R&D investment. We have also looked at the venture capital market. You know, overall, total venture capital funds have contracted from their peak. But if you look at the biopharmaceutical share of venture capital, it is actually expanded since its peak. And there is constant reports of very robust mergers and acquisition activity happening in the biopharmaceutical space.

Mr. Sarbanes. Thank you.

Dr. Ballreich. So there is a lot of doom and gloom rhetoric, but we don't see actual dollars, cents, business decisions, you know, changing.

Mr. Sarbanes. When this was coming together, the Inflation Reduction Act was very carefully crafted to ensure we are providing the right kind of incentives, ones that spur innovation to truly novel therapies that can demonstrate high value versus just the

repurposing of older products or similar drugs that already have many alternatives on the market.

Dr. Kesselheim, is research for novel therapies the kind of research we should be seeking and incentivizing? I think you would say yes. And is the IRA, in your view, drafted in ways it can accomplish this?

Dr. Kesselheim. Absolutely, it is. The IRA is intended to get Medicare to lead to a fair price, not a rock-bottom price, a fair price on a drug after it has already been on the market for 9 to 13 years. And so what it will do is it will disincentivize companies from their usual strategies of trying to extend market exclusivities on their existing products for as long as humanly possible and, instead, trying to direct companies to invest in more newer products that will provide meaningful improvement to patients.

Mr. Sarbanes. Thank you very much. I yield back.

Mr. Guthrie. The gentleman's time has expired. The gentleman yields back.

And the chair recognizes Dr. Burgess for 5 minutes for questions.

Mr. Burgess. Thank you, Chair Guthrie. And referencing your earlier remarks on the constituents you had with muscular dystrophy, many of these illnesses are, by their very nature, progressive, and any delay in establishing a therapeutic regimen means that there is going to be ground lost that can never be reclaimed.

And this committee did really important work several years ago on the Right to Try Act that got signed into law, and it really has -- I mean, I hear from constituents, particularly in the muscular dystrophy space, where that right to try has made a significant difference. So I just want to remind us all the work that we do here on this dais and at the witness table is extremely important for the future.

I recently introduced H.R. 7432, Sickle Cell Disease Comprehensive Care Act, to

allow State Medicaid programs to provide comprehensive coordinated care to patients with sickle cell disease through a home health model. Bobby Rush, who was a member of this committee for years, was concerned when we did the Cures for the 21st Century that we hadn't really established anything new for sickle cell disease. And he said it has been years since that has happened.

And we did -- have made significant efforts since that time to try to improve the lot in life for patients who are diagnosed with sickle cell disease. But the ability to coordinate care, I think, is going to be so important.

I do want to thank Congressman Danny Davis, who is not part of this committee, but has been an advocate for sickle cell, and Congressman Buddy Carter, who is on this committee, for their partnership.

I would just ask, Dr. Bassuk, if you could speak to the role that case management can play in helping ensure that patients, especially rare disease patients, get the care that they need?

Dr. Bassuk. Yes, absolutely. You know, as we have heard before mentioned that we have to coordinate the care, particularly with these new treatments. I mean, you mentioned sickle cell disease. It has been tricky. It is one of the first -- or the first genetic disease that we knew of where we knew the gene. And for a long time we didn't have great treatments, and now we have two just approved excellent treatments.

One is using what Dr. Flotte referred to earlier, this CRISPR/Cas9 therapy. Another one is using a viral vector, I believe, to -- yes, a lentiviral vector, to give the right hemoglobin, because the patients there have a problem with their hemoglobin. But when we give these therapies, I mean, for some of these the cells have to be removed, put back into the patient. This requires a literal team -- it can fill this room -- for one

patient. So we have to coordinate the care.

And that is just one example. Thank you.

Mr. Burgess. And thank you for that answer.

Ms. Davis, I do want to say thank you for being here today and sharing your very powerful story with us.

We have the Creating Hope Reauthorization Act to extend the FDA's authority to issue priority review vouchers. Seems like there was a recent instance of a rare small disease company anticipating receiving this voucher and only learned at the 11th hour that the FDA did not intend to grant the priority review voucher.

So could you speak to how this uncertainty adds another layer of complexity in this space that is already complicated enough?

Ms. Davis. Yes. And I can show where it is working, too, because SMA has two approved treatments -- three approved treatments, and two of those were awarded priority review vouchers. So there is an example of showing how it has worked.

What we need in the rare disease space is predictability and reliability. Our investors that provide the essential funding in bringing treatments to market really depend on that. And the priority review vouchers, getting to apply for those and secure those, provides an essential funding mechanism to provide additional funding for the smaller biotech companies that so frequently bring our treatments to market.

So it is one thing to secure approval for these treatments, but then once they secure approval, they have to have the funding in place to make sure that those treatments reach the patient. And that is what the priority review vouchers will do and mean for the rare disease community.

Mr. Burgess. Again, thank you for your presence on the panel today.

You know, it is so important, and we talked about a team approach to things. We are facing a situation in this country where we are losing physicians at an absolutely unbelievable rate. We had a hearing last week or the week before on physician burnout.

It is not surprising, when you work people as hard as doctors are worked, and it currently -- and then turn around with Medicare cutting prices. So price controls are not always helpful, and, in fact, they can lead to the shortages that were previously mentioned. And, unfortunately, we are going to see that in the physician space if we don't do something about it. I know this committee has done some work, but we have got a lot still to do.

So, Chair Guthrie, I thank you for the time, and I yield back to you.

Mr. Guthrie. Thank you. Dr. Burgess yields back.

The chair recognizes Mr. Cardenas for 5 minutes.

Mr. Cardenas. Thank you, Chair Guthrie and Ranking Member Eshoo, for holding this important hearing. And I also want to thank the witnesses for sharing your expertise and your opinions with us this morning before the American public.

Providing relief and life-saving help to people who have had little reason for hope is ultimately what this is all about. That is why I am thrilled to see bills that I support up for discussion today, including the BENEFIT Act, which would require the FDA to consider relevant patient experience data in their new drug approval process; and the Accelerating Kids' Access to Care Act, which would ensure that kids can cross State lines and retain coverage for specialist services to treat rare conditions. I am also glad to see that Give Kids a Chance Act on the list of bills today as well since it will ultimately improve the potential for treatment options for pediatric cancer. These bills will make life-altering

improvements for those who have had every reason to believe their suffering was inevitable.

I also want to thank Representative Eshoo for her leadership and innovation on pediatric populations. It is an incredible legacy to leave to ensure that kids with cancer and rare diseases have hope to treat their conditions. So thank you to our colleague, Anna Eshoo.

My first question is for Dr. Bassuk. In your opinion as a pediatrician, what kind of impact would policy like the Give Kids a Chance Act, which would authorize clinical trials for combinations of drugs to treat pediatric cancer, have on families who feel they have exhausted all of their options?

Dr. Bassuk. So I don't know the exact details of the bill, but I will just say the following. Before I was born, if you were born -- if you were a child with leukemia, you had a 90 percent chance of dying within 5 years. By the time I finished medical school, you had a 90 percent chance of surviving 5 years later. And that's because of research.

Last time I was on call, I was called to see a baby with a brain tumor. And I had to do something that sometimes pediatric neurologists have to do, which is a brain death exam, because we have no good treatments for brain tumor patients.

So there are clearly cases where we need to do more than we are doing, and we need to do everything that is available to us. And anything that gives us that kind of ability is something we are all going to support.

Mr. Cardenas. Okay. Thank you.

I also want to discuss the importance of using the most humane methods possible to test new innovations and therapeutics. This means we must move away from animal testing where and if at all possible. To be clear, this transition is not only an animal

welfare position but an imperative to advancing human health as well.

We know that approximately 90 percent of drugs fail in human tests after doing -- going through animal trials. In some cases, there is reason to believe that nonanimal methods are actually more effective, and failing to phase out harmful animal tests, where possible, leaves new innovations on the table.

I was glad to see the FDA Modernization Act 2.0 get signed into law last Congress. I appreciate efforts to try to implement those policies. Most importantly, though, we must ensure that these efforts are safe and effective for the populations they are intended to treat.

Dr. Flotte, you mentioned in your testimony that, quote, "Clarity on regulatory expectations for alternative testing methods is crucial, and research, development, and science-based adoption of such alternatives should be prioritized," end quote.

Can you say more about how FDA can speed effective new alternative methods to be more utilized?

Dr. Flotte. Thank you, Congressman Cardenas. The issue is a complex one, of course, because when certain new modalities, basic platforms of gene cell therapy, come to the fore, they require some level of animal testing in order to identify previously unanticipated adverse effects. So there is not a 100 percent substitution.

However, when a drug or biologic is approved, nowadays many of them are approved for a certain set of mutations in the gene. And if that span of mutations can be expanded using the same platform by using cell-based testing methods as opposed to animals, that will, as you point out, speed the additional indications.

So it is not an all-or-none issue, but it is clear that substitution methods can be faster.

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Mr. Cardenas. Thank you so much.

My time expiring, I am going to be submitting some questions to the panelists to answer in writing in due time.

So thank you so much, Mr. Chairman. I yield back.

Mr. Griffith. [Presiding.] The gentleman yields back.

I now recognize Mr. Latta for his 5 minutes of questions.

Mr. Latta. Well, thank you, Mr. Chairman. And thank you very much for our witnesses for being here and, Ms. Davis, for your testimony today. We appreciate you being here.

One of the privileges of serving on this committee is that we see firsthand years in advance the cutting-edge American innovation, what we can do to market those new treatments as soon as possible, especially those when we are talking about rare diseases. This committee has a long-standing history of working in a bipartisan fashion, and I am proud of the work we have accomplished in this Congress and in the years past.

However, I do believe our innovation to cure rare diseases could be at risk as a result of the Inflation Reduction Act. Medical breakthroughs have been made in treating rare diseases, such as cancer and Alzheimer's, and I fear that all the progress accomplished might be in jeopardy and hope lost for those seeking cures. We can and must come together to protect research into rare diseases.

And also, again, I want to thank all of those who have been in the research and development of these life-saving drugs and what they bring to market to help so many people across this country and across the globe.

Dr. Chen, innovation and drug development has come a long way, and that includes small molecule drugs. When we think about small molecule, what comes to

mind are pills that treat prevalent conditions in large populations, easier to pioneer and easy to manufacture. But thanks to robust innovation, the easy next therapies have largely already been developed.

These days, small molecule drugs require cutting-edge science with longer development timelines and complex manufacturing requirements, but they hold immense promise for patients, especially those with rare diseases.

How do we ensure incentives exist for the development of the groundbreaking small molecule drugs and a new paradigm established by the IRA?

Dr. Chen. Well, I think we need to make sure that prices match their value. If you are going to put a price control on a high-revenue drug and that high-revenue drug is a high-value drug, then all of a sudden incentives for the high-value drug have been reduced. And so that, I think, will hinder our ability to see the drugs that produce the most value come to our society.

Mr. Latta. Thank you.

Dr. Flotte, drug development is an iterative process, especially for oncology drugs. Often the majority of research in cancer therapies happen after the initial approval, including in earlier stages of cancer, and the overall rate of innovation accelerates over time.

While the Orphan Cures Act is a good first step, how can we ensure that there are incentives for continued innovation so that orphan indications for such things as life-saving cancer drugs that typically occur throughout the innovation life cycle continue to come to market?

Dr. Flotte. Thank you, Congressman Latta. It is a complex question, but I certainly would reiterate that many of the incentives that we have talked about to speed

regulatory review, to broaden the protections that orphan drugs have, and in some cases to define orphan conditions based on specific mutations, as in -- as in some types of cancer where globally a type of cancer may not meet the rare definition, but cancer do -- one particular mutation may meet that definition.

So in a variety of ways we work collaboratively with the FDA, but I think any legislation that enhances the investment environment so we can get more private industry funding for these types of treatments is essential right now.

Mr. Latta. Okay. Let me follow up. What diseases might be most possibly impacted by the passage of the MINI Act, and what would be negatively impacted if it does not pass?

Dr. Flotte. The ASGCT, as discussed, doesn't have a particular position on the MINI Act. There are a subset of the treatments in our -- in our catchment that are based on oligonucleotides, that is, synthesized short stretches of DNA or RNA, such as one of the treatments for SMA1, the Spinraza treatment.

We feel if they are treating rare disease, ultra-orphan diseases should be -- should receive favorable treatment and advancement.

Mr. Latta. Well, thank you very much.

Mr. Chairman, my time is close to expiring. I yield back.

Mr. Griffith. The gentleman yields back.

Now recognize Mrs. Dingell for her 5 minutes of questioning.

Mrs. Dingell. Thank you, Mr. Chair.

Last summer, I was contacted by the medical director of the Washtenaw County Tuberculosis Clinic, who was treating a patient, Shandra Eisenga, for a severe postsurgical tuberculosis infection. After a month battling a severe TB infection in the intensive care

unit, she died.

Shandra's physician was particularly alarmed since he realized she had recently received a bone graft that was manufactured by Aziyo Biologic, a company with a troubling history with contaminated bone grafts. In 2021, units of the contaminated bone graft manufactured by Aziyo Biologics were implanted into 113 patients. Eighty-seven of them developed TB infections and eight died.

Since Shandra's passing, it has been discovered that her death was indeed linked to contaminated bone graft material produced, again, by Aziyo Biologic. She was one of 36 patients who received material from the contaminated lot. And as of today, this latest outbreak is linked to the deaths of two people, including Shandra.

I am grateful that the chair included the Effective Screening and Testing for Tuberculosis Act and the Shandra Eisenga Human Cell and Tissue Product Safety Act as part of today's hearing. I am leading these two bills, along with my friend and colleague, Representative John Moolenaar, who is here, and he is joined by Shandra's sister, Tarin Brunink, who also happens to be John Moolenaar's staffer.

I want to thank you, and we all honor you today and grieve for your sister.

So John and I, and all of us, have been working closely with the Food and Drug Administration and the Centers for Disease Control and Prevention to better understand the manufacture and regulation of human cells and tissues to ensure they can be used to improve patient outcomes, not harm them.

Dr. Flotte, how does the use of human cells, tissues, and tissue-based products support your practice in caring for patients with rare disease?

Dr. Flotte. Thank you, Congressman. There are a variety of different kinds of cellular products. Some of which are combined with gene therapy, as Dr. Bassuk

mentioned, with the treatments for sickle cell disease require a cellular therapy with gene alteration or gene editing in order to be able to be used.

What your experiences point out, though, is that there are a wide range of cell therapies out there, some of which combine with gene therapies and some of which do not, and the regulatory science has to continue to advance in order to find out a better test for these unanticipated consequences, such as the one that you talked about.

Mrs. Dingell. So we have got to stop them. We can't -- we don't want to see anyone else die. How can we maintain the integrity and safety profile of these products?

Dr. Flotte. I don't know the specific case in sufficient detail to really address that particular one, but I think the point is that our regulatory frameworks, our testing for quality control cannot be static. When new potential dangers are identified, the treatments -- sorry -- the quality testing for the treatments has to be updated and improved.

Mrs. Dingell. So, finally, do you think the American public understands the risks associated with bone grafts and other donor materials? Do you think people who get a bone graft from their dentist or a bone graft for their back think, I could die from this bone graft?

Dr. Flotte. Well, I certainly don't have any data upon which to base an opinion like that. I would just simply state that right now is certainly within the purview of the provider of the physician or the dentist to, as accurately as possible, summarize the risks and benefits. But I don't have any data particularly on how well-informed patients are.

Mrs. Dingell. I suspect patients aren't told at all. So I want to thank you.

A few years ago -- people on this committee are tired of hearing about it -- but I

had multiple bone grafts because of osteomyelitis in my jaw, and no one ever gave me the risks. And that's why these pieces of legislation are so important. Taken together, they will take steps to ensure patients better understand the risks associated with bone graft materials and also improve testing and screening of tuberculosis in donor materials that are used in medical procedures.

I look forward to working with the members of this committee and my dear friend, Rep. Moolenaar, to ensure we get these bills right.

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

Mr. Guthrie. [Presiding.] Thank you. The gentlelady yields back.

And the chair recognizes Mr. Griffith for 5 minutes for questions.

Mr. Griffith. Thank you, Mr. Chairman.

Dr. Chen, I come from a little town in southwest Virginia, but I grew up with a family that was afflicted with Huntington's disease. And since that time, also knowing other family that, through an adoption where they had no way 40 years ago of knowing what was going on, that family now has learned that it also has Huntington's disease.

So in your testimony, you mentioned there are targeted therapies that directly address the underlying genetic causes of diseases, such as Huntington's and ALS. What are these therapies, and what does the future look for them?

Dr. Chen. You know, there are a lot of therapies out there that are still being developed, and the targeted therapies, in particular, are there to address, as you have mentioned, the underlying genetic mechanisms. And as we learn more in innovation and move toward sort of cell and gene therapy, I think we have more potential curative treatments down the road for us.

Mr. Griffith. You know, the situation, particularly with Huntington's, is so dire

that one member of that family has told me he doesn't want to be tested. He is afraid to find out whether he has the disease because there is nothing that can be done for it.

That said, do you think that some of the provisions of the Inflation Reduction Act, particularly the confiscatory and what I believe and have argued longly, unconstitutional provisions that is related to the fines if you don't cooperate with the Federal Government and negotiate the way they want you to, do you think that will hinder or enhance advancement of therapies for people facing these types of rare diseases?

Dr. Chen. The IRA has a carve-out for drugs with a sole indication for a rare disease. The challenge here is drug manufacturers who enter this space consider the entire pipeline of indications that they might get approval for. So what the IRA does is essentially disincentivizes drug manufacturers from entering a -- exploring a drug where the first indication is a rare disease. And it also further disincentivizes drug manufacturers from exploring further follow-on indications, which is a very cost-effective way of doing R&D for the rare disease space.

Mr. Griffith. So let me see if I can translate into layman's terms. If you are a manufacturer of medications doing the research and you have one that treats a genetic disorder and some of your think-tank team says it might help Huntington's, you are afraid to try it because then that would trap you into possibly having confiscatory fines or penalties put on you by the -- by Medicare or Medicaid. Is that correct?

Dr. Chen. That is exactly right. You are subject to -- potentially subject to price negotiations if you --

Mr. Griffith. So you are better off if you don't look; just keep it as the one disease. Okay.

Dr. Flotte, Huntington's disease, as we have discussed, is an inherited disorder.

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In your testimony, you mentioned the adeno-associated virus, which is a vector that targets specific cause of the disease and changes the way the cell functions. This is used to treat inherited diseases without treatment, which Huntington's would be.

Are you aware of any efforts to use this or to research this related to Huntington's disease?

Dr. Flotte. Yes, Congressman, there are, in fact -- there have been several -- several proof-of-concept studies using AAV to deliver a form of RNA interference. Huntington is a disease where you have to silence the bad gene and not simply add back a good copy of the gene.

So there was, in fact, two efforts that I am aware of. One was actually at University of Iowa by Dr. Beverly Davis using AAV to deliver this technology. The other is a series of studies being done at our institution, at UMass Chan Medical School, under the leadership of Dr. Neil Aronin, who is one of the people pushing the envelope forward for both gene-based therapies, that is, recombinant viruses, and oligonucleotide-based therapies, that is, synthesized stretches of DNA or RNA, that either one of which is designed to downregulate that offending gene.

Mr. Griffith. So let me ask you the tough question. If it is your friend who is afraid to get the test to find out whether or not he is carrying that gene for Huntington's, do you tell him that the new treatment looks promising enough to get the test, or should he just go on living his life in somewhat -- he is always worried about it, but more blissful because he thinks he probably couldn't handle the stress?

Dr. Flotte. Well, Congressman, unfortunately, I have been asked this question at different times, not specific to Huntington, but to many of the diseases that affect kids that I treat. I have learned not to make any guarantees.

But I will say there is reason to still have hope for conditions like this, because if we do what we can do, industry does what they can do, the foundations do what they can do, I am convinced we are going to beat most of these diseases in the end.

Mr. Griffith. I appreciate that.

My time is up. I have lots of questions for the record. I yield back.

Mr. Guthrie. The gentleman yields back.

The chair recognizes Dr. Ruiz for 5 minutes for questions.

Mr. Ruiz. Thank you, Mr. Chairman.

As an emergency medicine physician, I have treated patients of all ages with various health conditions. I have seen firsthand that there is unmet need for patients struggling with rare diseases.

We need to expand access to care for patients with rare diseases. We need to prioritize innovation so we can develop new and potentially life-saving treatments. And above all, we must not leave behind our most vulnerable patients, kids.

That is why I co-sponsored the bipartisan bill, the Give Kids a Chance Act, introduced by Rep. McCaul and Rep. Eshoo. This bill would provide for clinical studies of combinations of two or more cancer therapies for pediatric cancer. Studying combinations of therapies can help lead to new innovative treatments for children with cancer to help them achieve better health outcomes and live longer.

Dr. Bassuk, could you discuss the value of combinatorial studies of targeted cancer drugs for children with cancer?

Dr. Bassuk. Yeah. This is actually an easy one. If you look at any individual drug and test it for cancer as a sole therapy in kids, they are all going to fail. We know this because -- and if you look at adults, they have combination therapy, and it is

approved. We have to do combination therapy in kids.

The cancer cells are smart. They figure out what is going on with the drug and they find a work-around, so that is why you have got to gang up on them and use multiple drugs.

Mr. Ruiz. Dr. Flotte, in your testimony, you discussed the importance of clinical trials and challenges they face. Do you see a quick path from bench to bedside?

Dr. Flotte. That was to me?

Mr. Ruiz. Yes.

Dr. Flotte. The path from bench to bedside needs to be faster than it is now. There are many different ways to do that. Right now, certainly part of that is just the total amount of investment in this from all the parties, as I mentioned before, because these things take money and time, really, to know the real safety and efficacy.

But I would point out that, very often, as I -- as we talked about before, the window for an individual patient may close while these final stages of testing are being done. So anything we can do to speed approvals or speed entry even into the clinic is important. And one of those concepts is this platform technology, which we as a field are just working with what that means. But, basically, if something works in a given cell, to be able to substitute a different gene for patients who have a different but related type of condition.

Mr. Ruiz. And do you see companies embracing pediatric studies?

Dr. Flotte. Well, it is an interesting question. Companies do embrace pediatric studies more than they used to, having been in this field for a very long time. However, I will say that in -- there is a lot of risk for investors and for companies in this whole field of cell and gene therapies. And so incentives to offset the risk are truly important and

remain very important.

Mr. Ruiz. So ensuring patients have access to effective treatments is vital. But we also need to think more broadly about how both innovative treatments and early detection of cancer can save lives.

While it is not under consideration by the committee today, I would like to reiterate my support for another bipartisan bill, Mr. Chairman. I would like to reiterate my support for another bipartisan bill that I am an original co-sponsor of, H.R. 2407, the Nancy Gardner Sewell Medicare Multi-Cancer Early Detection Screening Coverage Act. This bill would increase access to multicancer early detection tests for our Nation's seniors.

Dr. Bassuk, can you talk briefly about why access to early detection and innovative treatment could help to reduce the burden of cancer for the most vulnerable, children and seniors, and how can increased access to clinical trials, early detection, and treatments help in reducing health disparities and cancer inequities?

Dr. Bassuk. Yeah. I mean, as has been discussed, I mean, many of these things, if we don't detect early, the horse is out of the barn, and we can't do anything for the patient. So early detection is absolutely key, and we are very interested in anything that helps with that.

To the question of expanding access to therapies, expanding access to clinical trials, some of the changes that this committee has made in the past and some of the ones that we are talking about today have already had effect.

So Iowa is a small State. We only have 3 million people. And because of that, we have, in the past, not generally been a site for phase one clinical trials for cancer. But now we have, just in the last year, because of the laws that we are talking about, we

are doing phase one clinical trials for kids in Iowa in Iowa. They don't have to go the East Coast, they don't have to go to the West Coast. And that is because of this kind of legislation.

Mr. Ruiz. Thank you.

You know, I urge my colleagues to support both H.R. 3433, H.R. 2407, and I urge committee to include these bills in any healthcare package that is being worked on.

Thank you, and I yield back.

Mr. Guthrie. Thank you. Dr. Ruiz yields back.

The chair recognizes Mr. Carter for 5 minutes for questions.

Mr. Carter. Thank you, Mr. Chairman.

I am down here in time-out. Thank you all for being here. This is extremely important. Thank you, Mr. Chairman, for this hearing. All of these bills are extremely important.

As has been pointed out during this hearing, there are over 30 million of our fellow Americans who suffer from rare diseases and need our help, and the vast majority of those 30 million don't have any cures or any effective treatments, and that is one of the reasons why we are doing the work that we are doing in this committee because we want to address that. And it is important that we have legislation that will bring our healthcare system into the 21st century so that we can help many of these with rare diseases get the treatments that they need.

I recently introduced the FDA Modernization 3.0 Act. That would establish a program at the FDA to qualify preclinical testing methods that will reduce or replace the use of animal models. It builds on FDA Modernization Act 2.0. 2.0 was the first step. This is the next step.

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And what we are trying to do, of course, is just to give incentives or to really make sure that the pharmaceutical manufacturers can use the animal models and make sure that we are doing investigation on drugs and the patients in the clinic.

As a pharmacist, I know how important it is to have -- to make sure that we are doing this. I have seen so many drugs that went on the market and then were pulled off a short time after, and that is the kind of thing we are trying to guard against.

Dr. Flotte, let me ask you, before investigational drugs reach the patients in your clinic, they must go through preclinical safety trials. I know that. Do you agree that the FDA should be -- should help foster the development and acceptance of preclinical nonanimal testing methods, particularly when it comes to evaluating the safety of the therapies you spoke about in your testimony?

Dr. Flotte. As I mentioned earlier, it is a complex question because new platform technologies clearly will need some animal testing because the cell models don't recapitulate every organ of the body that may be affected by a toxicity. But I do think that there are indications where it is either a small increment on an existing treatment or using the same platform where substitution of nonanimal models, particularly cell culture models, IPS cells and the like that have actual patient mutations can and should be used.

Mr. Carter. Can you share with us your observations about how nonanimal testing methods can better leverage and speed up the development of life-saving drugs?

Dr. Flotte. Well, one example I know that -- that has been well-described is that in cystic fibrosis, the CFTR modulators that were referred to earlier were initially each approved -- so that would include the current standard care Trikafta and some of the earlier predecessors -- they were initially each approved for it, a relatively small range of mutations in the gene.

Expansion of that label in many cases has been done with some form of cell model that has the mutation, the additional mutations, or has -- are examples from patients with other mutations. So in that case, it did not really require to get a new indication going all the way back to preclinical animal testing.

There are also examples where unanticipated toxicities come about that preclinical animal testing could help with, but in some of those cases, the animal testing did not accurately predict the end organ toxicity.

Mr. Carter. Okay.

Dr. Flotte. So it is a complex regulatory science.

Mr. Carter. Understood. Understood. Now I want to shift gears real quick. And one of the things that we are trying to do in this Congress -- and our chair has been a very strong advocate of this -- is to address PBM reforms, particularly as it relates to spread pricing, as it relates to transparency, and delinking the price of the drug from the profits that the PBMs are able to garner.

Dr. Chen, you described how -- can you describe how government price controls not only destroy innovation but also how it will make it harder for patients to access medicines when PBMs can still prefer higher-priced drugs to lower-priced drugs?

Dr. Chen. So in addition to the incentives manufacturers face from -- that are introduced by market revenue, the challenge here with PBMs is it affects insurer formulary coverage, step therapy, prior authorization that can limit a patient's ability to access generics and biosimilar entries -- entrants that come onto the market.

Mr. Carter. Great. Great. Again, thank all of you for being here. This is extremely important, particularly those 30 million Americans who suffer from rare diseases. So thank you all.

And I yield back.

Mr. Guthrie. Thank you. The gentleman yields back.

And the chair recognizes the ranking member, Mr. Pallone, for 5 minutes.

Mr. Pallone. Thank you, Mr. Chairman.

The Medicare Drug Price Negotiation Program focuses on a small subset of single-source drugs that cost the Medicare program the greatest amount of spending year after year and not drugs targeted for small and rare patient populations. To make this clear, the law included a specific exclusion for orphan drugs that treat a rare disease. However, Republicans would like to expand this exclusion to permit a much broader set of drugs to be exempt from negotiation, and that would undermine the benefits of the law and keep prices high for more beneficiaries.

So I have a series of questions, Dr. Kesselheim, but you have to answer them quickly because I have a number of questions.

You noted in your testimony that H.R. 5539, the Orphan Cures Act, and H.R. 5547, the MINI Act, will make rare disease drugs less affordable while not meaningfully shifting incentives for innovation. So if the orphan drug exclusion was expanded to include drugs with one or more rare disease indications as drafted in H.R. 5539, what impact would this have on the negotiation program?

Dr. Kesselheim. I think it would undermine the negotiation program. It would expand the exclusion to cover 10 percent of Medicare spending, which covers both single orphan and multi-orphan drugs. And it would not -- I think that manufacturers already have a lot of incentives to test their drugs in those additional indications, because these are extremely profitable drugs making billions of dollars over multiple years in revenues.

Mr. Pallone. Now, this bill would also further delay when drugs could be subject

to negotiation by changing the timing of eligibility until the approval of a non-rare indication. Despite the clear intent of the law, the eligibility runs from the initial approval of the drug.

So do you expect that manufacturers would likely attempt to game this provision in order to avoid negotiation for potentially more than a decade or longer?

Dr. Kesselheim. I think gaming is definitely in the cards. And I think it is also important to recognize that if you delay negotiation, you also reduce the number of drugs that would qualify for negotiation because they wouldn't qualify by the time that the manufacturers finally get around to ending all of the games that extend their exclusivity. And so that just reduces the benefits of negotiation to both the healthcare system and to patients who would rely on the fair prices that would come out of the negotiation system to help them -- to help improve access to those drugs that they need.

Mr. Pallone. All right. And, additionally, H.R. 5547 similarly delays negotiation for a certain subset of small molecule drugs. So how would delaying negotiations for 4 additional years for these drugs impact the Medicare program and beneficiaries?

Dr. Kesselheim. There doesn't seem to be any reason to try to exclude those drugs from negotiation or to delay those drugs from negotiation because the kinds of drugs that are described in that bill, if there is any clarity as to what those drugs might be, are extremely profitable drugs to their manufacturers and already have substantial incentives for investment in them.

Mr. Pallone. Well, thank you, Dr. Kesselheim.

There is no reason why we should be further limiting the scope of drugs or further delaying the ability for Medicare to negotiate fair prices. These bills only undermine the ability to deliver savings for patients, particularly those with rare conditions.

And I also continue to have concerns about reauthorization of the pediatric rare disease priority review voucher and several of the other pieces of legislation before us that will require FDA implementation. I believe it is important to hear from FDA on this bill and the other FDA-related policies under consideration prior to any committee action, as many of these policies require significant agency resources and it is important for the committee to fully understand the utility of some of these policies before moving forward.

You know, I am just going to go back to what I said earlier. And I am going to be repetitive, but I have to say that, you know, as I think some of you know, I was one of the key sponsors to the drug pricing reform provisions included in the Inflation Reduction Act. And I am just aware of the intent of the drug price negotiation program as drafted.

But to reduce prescription drug costs for Medicare beneficiaries while protecting access to new therapies and cures, we can do that. And the problem is that the bills we are considering today to amend the Inflation Reduction Act undermine this intent.

Again, it goes back to the thing that, you know, Republicans keep saying over and over again, you can't negotiate prices and have innovation at the same time. I don't believe that. I think that is a false premise. And, again, I don't know what the point is of having the drug if you can't buy it and you can't use it. Lack of access is -- if you don't have access, what is the point of having the drug?

So anyway, let me -- I know I sound like a broken record, but I am going to keep up with this broken record.

So thank you, Mr. Chairman. I yield back.

Mr. Guthrie. The gentleman yields back.

The chair recognizes Dr. Dunn for 5 minutes.

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Mr. Dunn. Thank you very much, Mr. Chairman, for holding this hearing to discuss a wide array of policies aimed at improving the lives and outcomes of those with rare diseases.

I appreciate that many of my colleagues have been in the fight to eliminate this fail-first therapies and improve prior authorizations for doctors, their staffs, and, most importantly, for patients during the entire time I have been in Congress.

Preserving the doctor-patient relationship has been the driving force behind many of my healthcare priorities since I have been here. And, unfortunately, it is getting more and more difficult to make sure that the right drug gets to the right patient at the right time. This often causes great harm to the patients. Prior authorizations often delay appropriate care, and step therapy might as well be called fail-first medicine. As a physician, neither are acceptable to me, and it shouldn't be acceptable to you either.

Rare disease patients can face significant challenges when it comes to obtaining access to appropriate treatments due to insurance policies, medical necessity requirements, et cetera. In many cases -- in fact, probably in most cases -- the medications that are most effective for treating and managing rare conditions are used off-label. These treatments are often dramatically effective and very logical, but they are off-label.

Years ago, cancer patients also got stuck by this problem, and a lot of cancer treatments were labeled first line or second line, et cetera. So, for example, if a doctor had a good reason to use drugs in a different order or in different combinations, the treatment protocol might have been considered off-label and disapproved by insurers. And I can't tell you how often I face that dilemma in my clinical practice.

Congress recognized this roadblock and addressed it by directing payors to look

beyond the label to compendia and peer-reviewed journal articles, et cetera, to meet the threshold question of medical necessity and appropriateness. Building off that successful effort, it is now time to allow for similar flexibility in the rare disease space.

H.R. 6094, the PROTECT Rare Act, would amend medical necessity standards for rare disease patients so that peer-reviewed medical literature and published clinical guidelines, in addition to the simple FDA safety approvals, would satisfy the medical necessity requirements of the statute. I appreciate my colleague, Ms. Matsui, for working with me on this important legislation.

So why is it necessary in the rare disease space? Why should a treatment be used outside of the indication that it was originally approved for? Well, new therapies are frequently coming to market for rare disease, and small trials with small numbers of patients with heterogenous symptoms mean very narrow labels. That is not because the drug doesn't work. You know, they are diseases. But because the manufacturer could not afford to initially test all of the diseases for statistical significance across a heterogenous set of patients or the various related diseases that they are studying at the time of FDA approval.

Subsequent research by academic institutions and medical experts may lead to the development of clinical recommendations and peer-reviewed medical literature that suggests that the use of the medication is effective in treatment or management for a broader range of rare diseases. Despite new evidence, manufacturers rarely seek a label change once the product is on the market due to the associated costs. And, therefore, a group of potential patients lack coverage for their indication.

The PROTECT Rare Act would ensure access to FDA-approved treatments supported by peer-reviewed medical literature for rare disease patients. And I humbly

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ask that my colleagues join me in supporting this commonsense bill that will increase access to lifesaving cures and ensure more effective treatment of rare diseases.

I would like to describe one story from my district that puts a finer point on this. A young lady in Tallahassee was living with immune thrombocytopenia and repeatedly directed to -- by insurance coverage to receive IVIg treatments at roughly $175,000 per treatment. She and her doctor identified another infused drug indicated for use in several types of leukemia that has shown results in managing her disease. The drug cost $10,000 per infusion with fewer side effects.

Why didn't the manufacturer of the less expensive drug simply go to the FDA, ask for a new label? Because it is cost-prohibitive for them. Label indications for patient populations of less than a thousand when their drug already has a biosimilar on the market are simply not cost effective. That is why we need the flexibility. We need to intelligently approach this, and I urge everybody to support the PROTECT Rare Act.

With that, Mr. Chair, I yield back.

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RPTR DEAN

EDTR HUMKE

[12:03 p.m.]

Mr. Guthrie. Thank you. The gentleman yields back and the chair recognizes Ms. Kuster for 5 minutes for questions.

Ms. Kuster. Thank you, Chairman Guthrie. And thank you to our witnesses for being with us in this hearing that is going a bit long now.

This hearing is an opportunity to recognize the impact for rare disease on the lives of millions of Americans across the country, including in my district in New Hampshire. It is also a chance for this committee to address barriers to care, as you have heard from our questions. For many patients with rare diseases seeing that doctor often requires traveling to a different State and presents a significant barrier to receiving care.

I will tell you a quick story about a child named Georgia, a 6-year-old girl from New Hampshire. When she was just a few weeks old she needed surgery to correct a chronic intestinal pseudo-intestinal obstruction. Her local hospital could not perform the surgery. But thankfully, New Hampshire had a longstanding partnership with Boston Children's Hospital. Thanks to that collaboration she received the care that she needed when she need did it. But other children are not as fortunate.

In another State without access to advanced medical care, a 1-year-old with a rare complex congenital heart disease is racing against the clock to find treatment. Her anatomy is determined to be too complex for surgery close to her home. Boston Children's Hospital is ready to receive her, but first her surgeons must go through hurdles to enroll her in the home State's Medicaid program in order to get the authorization to provide care. Right now she and her family are still waiting at a Children's Hospital in

her home State hoping the paperwork goes through in time to transfer her to Boston and save her life.

Dr. Bassuk, have you had patients and families in your care while they waited to access expertise outside their State or insurance network? And could you describe how that wait impacted their health?

Dr. Bassuk. We absolutely have had that in our State. We have had it both ways, patients who want to come be seen by us, who have unnecessary hurdles thrown up and vice versa. Although, since I am the chair of the department, I want to say that all kids in Iowa should come to the University of Iowa and we certainly welcome them, it is the best place.

But a point of fact I can give you one example where somebody was really very far. It is a pretty big State. And they had a much closer children's hospital. And they had a very severe kidney disease. And they were left with -- they were told that they couldn't go to the other children's hospital. And this patient ended up getting so sick that the family actually -- a lot of expense to them had to move closer to our hospital just because now she went from not needing dialysis, to needing dialysis multiple times a week.

I asked my faculty anticipating this hearing to give me cases, I have two pages of such cases. It is a absolutely huge problem.

Ms. Kuster. Thank you.

Well, because of New Hampshire's unique geographic position, Dartmoth's Children's Hospital in my district often sees patients from neighboring New England States, including Vermont.

In your experience, Dr. Bassuk, has the process for waiting for another State's

Medicaid paperwork to process affected the experience of families whose children are undergoing this treatment.

Dr. Bassuk. Absolutely. You know, we have 50 different Medicaid programs unfortunately, pretty much. In the State of Iowa I think it takes about 30 days. So I think it is pretty good, I think it is still too long.

But other States require fingerprinting background checks, we have to send them our Social Security numbers and then might still say no. And it is 3-month or 4-month process and the kids can't wait that long. For some of these diseases if you have intractable epilepsy and you are waiting, something we can do at our center. We have a comprehensive epilepsy program. And it means you are having more and more seizures.

And we know in epilepsy the more seizures you have, the more; likely you are going to have uncontrolled seizures going forward. So this comes up unfortunately all too frequently.

Ms. Kuster. Well, thank you.

And I am proud to support the Accelerating Kids' Access to Care Act, legislation that would tremendously help children and their families access specialized out of State care. Removing barriers to streamline Medicaid provider enrollment would be a win for rural families. And I urge my colleagues support this bill.

And with that I yield back with 30 seconds extra.

Mr. Guthrie. Thank you. The gentlelady yields back. And the chair recognizes Mr. Pence for 5 minutes of questions.

Mr. Pence. Thank you chair Guthrie, and Ranking Member Eshoo. And thank you to the witnesses all being here today.

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We are considering several bills today that would increase innovation and improve treatment options for patients suffering from rare diseases. According to the National Institutes of Health there are more than 10,000 known rare diseases. However, we only have safe and effective treatment options for a few hundred.

I am proud that pharmaceutical innovators in the Hoosier State, my State, such as Eli Lilly, are leading the charge to develop groundbreaking medicines. But we know developing cures for rare diseases is incredibly challenging. That is why I would like to speak in support of the ORPHAN Cures Act today, championed by my very good friend, Dr. Joyce.

The ORPHAN Cures Act would make a critical fix to the Inflation Reduction Act's price setting provision by incentivizing continuing innovation for rare disease treatments that could yield additional applications.

Without a fix, the IRA disincentivizes products from pursuing indications for multiple rare disease populations, which will not only limit the application of drugs coming into market, but will also discourage investment and development in the next generation for cures.

It is important that we do not let red tape and burdensome regulations stifle innovation for the nearly 30 million Americans living with rare diseases. I was personally recently saddened to learn that two of my constituents Robin and Joel, whose grandfather worked for my family, recently lost their son Justin after a courageous fight with a rare form of disease.

All children, as you Ms. Davis, are gifts from God. And we should incentivize research and development that gives them the best chance of leading a successful and healthy life.

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Dr. Chen, in your oral testimony and then in written I am going to quote you here, you say, the IRA does not extend this exemption from future price negotiations to drugs with multiple indications whether they are primarily orphan drugs or not.

Consequently this diminishes the incentives or from drug manufacturers have to do it for exploring alternative uses for existing drugs and treating other rare diseases. When the chance and cost of failure is so high, how can we better incentivize drug manufacturers like Lilly to take risks or incentivize an innovative treatment, particularly referring to drugs with multiple indications.

Dr. Chen. You can't evaluate the value of a lottery by looking at the winners. In the same way, you can't evaluate the innovation pipeline by looking at only the blockbusters. And in order to incentivize innovation, we need to really consider the cost of failing from phase one to two, two to three and three to approval.

And in order to do that, you need to incentivize manufacturers with expected revenues, in particular the rare disease space, where the expected revenues are inherently low due to the smaller market size for patients.

Mr. Pence. And what did you mean by expected revenues? So taking off any price negotiations? Is that --

Dr. Chen. Well, so expected revenues simply means the life stream of money that a manufacturer anticipates receiving based on the price of the drug and the number of patients they will sell the drug to. The price of the drug should reflect value, as I have said in my statement. And that should be sort of the way we think about expected revenues.

Mr. Pence. So in a sense, let the free market kind of drive that, not the regulators?

Dr. Chen. Well, so there needs to be incentivizes for drug manufacturers to innovate. And after an appropriate level of incentives, there needs to be a market competition to bid down that price of that drug.

Mr. Pence. Okay. Thank you.

Mr. Chairman, I yield back.

Mr. Guthrie. Will you yield to me? Will you yield to me?

Mr. Pence. I will yield the chairman the balance of the my time.

Mr. Guthrie. I want to say that a lot of people have said today that we are saying that we wont have innovation. We haven't said that. We don't say innovation will go to zero. But we know from the CBO score when we did the bill that there will be less innovation because economic incentives are for less innovation.

And so to say that we are saying it is stopping everything is -- and then point to examples of it moving forward is just not accurate of the argument we are saying. We had members on the other side during the committee hearing when we were marking it up, we brought up the CBO scores say, we may get less cures but we are going to get cheaper prices.

And we all want low prices, that is what we want. The question how do you get low price innovation at the same time. And we are working on lower costs, more transparency throughout the entire healthcare system we want more affordability because it is necessary.

And thank you for yielding to me and your time has expired. And I will yield back to you and you yield back.

The chair will now recognize -- Dr. Schrier, you are now recognized for 5 minutes.

Ms. Schrier. Thank you to chairman Guthrie. And thank you to all the

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witnesses for being here today. It has been a really interesting discussion.

As a pediatrician, I have to say I am so happy that the committee is taking up so many pediatric-focused bills today and that you are all focused on this, rare diseases, as we heard, impact children the most and so the treatments do too.

Ms. Davis, thank you for sharing your story. And I want to extend my condolences. You also brought up the role of newborn screening in Hunter's disease. And as a pediatrician, one of the first things I wanted to emphasize was the importance of early identification and treatment of so many of these rare diseases.

And that one of the most important tools we already have at a very low cost, a simple newborn screening the heel stick that all new babies get in this country. And the common denominator for all 55 of these recommended screenings is that these diseases are rare, but if you detect them early and treat them early, you can give most of these kiddos the gift of a healthy normal life.

And sometimes the interventions are just dietary restrictions like with PKU or galactosemia for others they are on medications or gene therapies that we have heard about today. But without early detection, diseases like these including cystic fibrosis and congenital hyperthyrodism can lead to severe developmental impacts, illness, disability or death. And that is why I am so excited about today's discussion.

I first would just like to focus on the Accelerating Kids' Access to Care Act. In Washington State we are proud to have both Seattle Children's and the University of Washington at the forefront of rare disease research and treatment.

So patients from Alaska, Idaho, Montana, Wyoming travel across State lines to Seattle, Seattle Children's, quite regularly for diagnosis and care for rare diseases that is just not available in their own States. And this presents, as we have heard, a challenge

for children on Medicaid.

Medicaid State plans require out of State providers to be screened and enrolled in their program even if that provider is already enrolled in good standing in their own home State. This means that a child from Idaho seeking care in Washington for a rare disease may have to wait months for care, delaying care and treatment.

And that is why I strongly support the Accelerating Kids' Access to Care Act. As I mentioned with newborn screening, early diagnosis and treatment is critical.

Dr. Bassuk, you mentioned CRMO in your testimony and I happen to have had a patient with CRMO who was fortunate to live within a half hour of Seattle Children's. I was wondering if you could give us a couple more examples of one or two patients either yours or, you know, theoretically who were or could have been harmed by a prolonged delay in seeing an out of State specialist.

Dr. Bassuk. Yeah. So we recently had a case of a child with intractable epilepsy who was on out of State Medicaid. As I mentioned we have a comprehensive epilepsy center. And we have some things that are different.

So we have for example, something called a transcranial magnetic stimulation center of excellence run by Aaron Boes, who is our division director of neurology. And this is a very, very powerful magnet that you can use to briefly turn off parts of the brain. And it is used a lot for research purposes but we use it clinically.

And it has FDA approval for some clinical uses, including mapping out what parts of brain you can safely remove for a child with intractable epilepsy. So we were all ready to do this patient and our neurosurgeons know how to do these epilepsy surgeries. The patient was ready, the patient just had to sit home and continue to have seizures until we could get approval.

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Ms. Schrier. Which is damaging for their development.

Dr. Bassuk. And, you know, I am a pediatric neurologist, I see seizures all the time, it is scary for me still.

Ms. Schrier. Yeah, understandable.

Dr. Bassuk. It is very difficult for families.

Ms. Schrier. I want to move on to just two more quick comments. I just want to submit a statement for the record from the patients And Providers for Medical Nutrition Equity Coalition in support of H.R. 6892, the Medical Nutrition Equity Act. And I look forward to working with the chairwoman and ranking member on this.

[The information follows:]

******** COMMITTEE INSERT ********

Ms. Schrier. I would also just like to quickly address an issue raised so many times in today's hearing about Medicare drug price negotiation impacting rare disease research. This is a red herring. There are 10 drugs undergoing price negotiation right now. The likelihood of a pediatric rare disease treatment, kids are not covered by Medicare in the first place, being adversely affected by there is highly unlikely.

And I have no time left and I yield back. Thank you.

Mr. Guthrie. Dr. Schrier yields back.

And the chair recognizes Dr. Joyce for 5 minutes for questions.

Mr. Joyce. Thank you, chairman Guthrie and Ranking Member Eshoo and to the committee for including two pieces of legislation, H.R. 5539, the Orphan Cures and H.R. 5547, the MINI Act. In this hearing, these are critical, critical pieces of legislation to the future of patient treatment and to the access to cures in the rare disease space.

Both bills, which represent narrow and concise fixes to the IRA to ensure that research and treatments and future innovation that American patients want and American patients deserve are recognized.

I want to be clear on what these legislative efforts represent. These are not in any way meant to undermine or alter the fundamental negotiation mechanisms that were past in the IRA but rather drive more investment into the rare disease space to develop the next generation of cures and the next generation of therapies. In diseases like Merkel cell carcinoma and gliobalstoma can give patients and their families hope.

The Orphan Drug Act was signed into law the same year that I graduated from medical school. And I have been able to witness firsthand the life changing and significant innovations in treatments and cures because of that act. The diagnosis of metastatic melanoma that previously carried with it too frequently a referral into hospice

care in short order can now be treated and patients can go on to live. Of note the first cellular therapy for metastatic melanoma was just announced this month.

In fact, since the passage of the Orphan Drug Act, almost 1,200 new medicines have received FDA approval with orphan designation. I hope that everyone on this committee, regardless of party affiliation wants the level of drug innovation to continue in treating diseases.

I would also like to add that the passage of the IRA, the orphan provision in section 1192, is an acknowledgment that orphan disease treatments are meant to be shielded from the negotiation protocol and that the bills we are considering today is merely an effort to improve that exemption for the patients who ultimately will receive treatment from these future innovations.

In a similar vein, the MINI Act narrowly targets therapies utilizing, genetically targeted technologies or GTTs. GTTS were defined for the first time in the 21st Century Cures Act and captured two categories in genetic therapies akin to the biological technologies, small interfering RNA and antisense oligonucleotide.

GTTs are still in their infancy and subjecting these highly complex small molecule drugs to negotiation timelines intended for simpler drugs will disproportionately impact the innovation ways to treat diseases with high unmet medical need. Rare diseases are those defined as effecting fewer than 200,000 Americans.

And while rare diseases may individually impact a relatively small number of patients, collectively their impact is far reaching affecting 30 million Americans or roughly one in one in 10. In 2023, research resulted in 71 novel approvals, including new treatments for rare and hard to treat conditions. Personally, I am the survivor of a rare pediatric cancer. I lived and that impact still impacts me every day.

Dr. Chen, from an economic perspective, can you speak to the value of post approval research into additional indications and what that means for patients, specifically in the rare disease community?

Dr. Chen. Absolutely. So the post approval pipeline of R&D is a much more cost effective way of doing R&D. You already now what the drug is, it has been approved for one indication. And the ability to test that drug and multiple other rare disease indications is valuable because the incentive to do that might not have been there if you had to develop the drug from the start all the way at the very beginning of this process.

Mr. Joyce. Finally, Ms. Davis, thank you for being here. Thank you for sharing the story of the loss of your husband due to glioblastoma. Can you speak to the importance of continued progress of rare conditions for your family and the rare disease community.

Ms. Davis. With 95 percent of rare conditions lacking an approved treatment, we must continue to drive innovation so patients with unmet needs can access the treatments for their conditions.

Mr. Joyce. To conclude, thank you to all the witnesses and know that patients can only access and afford orphan medications if they first exist.

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

Mr. Guthrie. Dr. Joyce yields back.

The chair recognizes Ms. Barragan for 5 minutes for questions.

Ms. Barragan. Thank you, Mr. Chairman.

Rare disease patients experience inequities in diagnosis in care to a lack of investment in research and a lack of awareness among healthcare providers. The

average time from the start of symptoms to a diagnosis of a rare disease is 5 years. And this is even longer for patients of color. Additionally, the majority of rare diseases do not have an FDA approved treatment. I am glad to see that the committee has a hearing to address these issues on Rare Disease Day.

Dr. Flotte, because of how few people are affected all childhood cancers are considered rare which is why I am proud to co-lead the Creating Hope Reauthorization Act with several of my colleagues. This bill will extend a priority review voucher program that provides incentives to develop treatments for rare pediatric diseases. How has the priority review voucher program been used to accelerate research for rare disease that otherwise would not have been invested in?

Dr. Flotte. Thank you, congressman. I can relate only a few specific examples where we know that investors, particularly in riskier avowed tech sector have viewed the potential eligibility for PRVs as an incentive that can offset some of their risks. So we support continuing the pediatric priority program.

Ms. Barragan. Well, thank you. And I want to thank the Kids v Cancer, the EveryLife Foundation and all the other stakeholders who have worked to support this bill.

Now Dr. Flotte, the FDA Modernization Act 2.0 was passed into law in 2022 to support the use of alternative methods that reduce or replace the use of animals in nonclinical tests. 14 months later the FDA has not implemented the law. I am proud to stand with Animal Wellness Action and co-lead the FDA Modernization Act 3.0, which provides additional clarity for these alternatives to be accepted by the FDA and utilized by drug developers.

Animal biological models that the FDA has relied on for drug testing do not resemble human biology. But with human relevant models drug testing can be more

productive.

In the transition to these human drug testing models, how can the FDA ensure that these models are representative of the diverse populations who will rely on these drugs?

Dr. Flotte. It is actually an excellent question about the diverse populations because the power many of these alternative models which are based on human subculture are that they recapitulate the disease in terms of individual patient mutations.

So in terms of the diverse applications one really has to think about what the disease who it affects and how the cell models or alternative models reflect the population that the drug is intended for.

Ms. Barragan. Great. Thank you

Dr. Chen, today marks the end of Black History Month when we honor the triumphs of struggles of Black and African Americans. Sickle cell disease is a genetic blood disorder that effects approximately 100,000 Americans. But people of African decent are affected at much higher rates compared to other groups. Despite the sickle cell disease has been historically underfunded.

The Sickle Cell Disease Comprehensive Care Act would allow State Medicaid health home programs to provide care to people with sickle cell disease. Can you describe what Medicaid health homes and how they can help address gaps in the care currently received by these patients.

Dr. Chen. So Medicare -- excuse me, Medicaid health homes are very variable across each State. It is a State implemented program. But the care coordination essentially that Medicaid health home offers tries to ensure that patients have access to the primary care specialist care that they need.

And in our own research looking at care coordination models, such as the Accountable Care Organizations we found that care coordination is important in reducing healthcare expenditures.

Ms. Barragan. And so will this help families be able to provide care for their loved ones?

Dr. Chen. To the extent that care coordination can help you access the medical care that you need, absolutely.

Ms. Barragan. Thank you.

Dr. Bassuk, my district has a significant Medicaid population which is why I am a proud cosponsor of the Accelerating Kids' Access to Care Act. This bill will clarify Medicaid and CHIP process so that families are able to get specialized care that may not be available in their home State. As a pediatric neurologist, can you share why it is important to ensure children from low-income communities are able to access the services that they need?

Dr. Bassuk. Yeah, we need to get kids the best care available for them where they are. And if it is not available where they are, we have to bring them to where the care is. So that is absolutely why we are -- we and many of the societies that we belong to, I mentioned a few of them, the Children's Hospital Association are absolutely behind this bill.

Ms. Barragan. Well, thank you.

Every kid regardless of ZIP Code, regardless of income should have the same access to the equal care.

With that, I yield back.

Mr. Guthrie. Thank you. I 100 percent agree.

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The gentlelady yields back and the chair recognizes Mrs. Harshbarger for 5 minutes.

Mrs. Harshbarger. Thank you, Mr. Chairman. Thank you to the witnesses for being here.

I will start with you, Dr. Chen. Today under the pediatric research equity act or PREA, certain orphan drugs are exempt from requirements to conduct pediatric studies. What characteristics do orphan drugs have such that they might be exempted from these requirements?

Dr. Chen. You know, I am not quite familiar with all of the details of the requirements for orphan drugs for pediatrics. But it is important to ensure that we have incentives to innovate in that specific area.

Mrs. Harshbarger. Okay. Can you tell me or expand on potential unintended consequences of requiring such studies for orphan drugs on future development decisions? Because you know, in your testimony you were talking about drug development and investments. And on average, 90 percent of these drugs fail. And, you know, then you have got 10 to 15 years required to progress from initial discovery to market approval.

And, you know, when you are in that space and I have been a pharmacist 37 years and you know what it takes to get them from clinical trials and up. You know, there is a lot of chance that they never make it to market.

Dr. Chen. That is absolutely right. And, you know, we know that without incentives like the Orphan Drug Act 90 percent of the drugs that we see that have come out of that space to treat specifically rare diseases would not have occurred.

Mrs. Harshbarger. You spoke about the benefits of exploring potential follow-on

uses, the existing orphan drugs to treat other rare diseases. And you said that follow-on indications represent a critical pathway for faster and more cost effective innovation, especially in the realm of rare disease treatment.

However, the overly narrow construct of the Inflammation Reduction Act orphan drug exemption could significantly discourage future research programs in rare disease. And the ORPHAN Cures Act would correct this by allowing medicines that treat one or more rare diseases and only rare diseases to remain exempt from Medicare drug pricing negotiation.

So my question is, do you believe this solution would reduce the burden on the innovators to pursue research and development for the disease patients without treatments.

Dr. Chen. Yeah, precisely because follow-on indications represent a cost effective way to do or even explore in the space that is have important. I think it is important to note that, as we have heard today, that only 500 of the rare diseases have a cure. And some of these are very low prevalence populations. And because of that the incentives for innovating in that space is particularly low.

Mrs. Harshbarger. You know, some of these rare or ultra rare diseases may have 50 patients and I mean a very low number of people. And the bottom line is if you are wanting to invest in these companies, you have to have an incentive do that. It has to be profitable. And how many times have we used drugs off label?

Physicians in the audience? I mean, we have used them multiple times for different diseases. They may come up with something that is cures later on down the road. You have to go back and go through the whole process again if it is not conducive.

I guess the last thing, Dr. Chen, is an expert in health policy and as an economist

can you explain the challenges posed by the current policy environment to where disease drug development? And what does the future look like if it is left unchanged?

Dr. Chen. You know, the challenge here is designing a policy where we ensure that we get the drugs that patients really value. And we want to create incentives for manufacturers to innovate for those high value drugs. In particular for the rare disease space we know patients really value those treatments.

And we should take into account not just the clinical benefit of those drugs but also the patient preferences for those drugs.

Mrs. Harshbarger. It might not have stopped innovation, but it certainly has stifled it and that is my opinion. I have only got, like, 52 seconds left.

Dr. Flotte, you talked a little bit about manufacturing technologies, decentralized trials and real life stories. And tell me how that works? To me it makes a lot of sense that you would include that, so tell me a little bit about that.

Dr. Flotte. Well, actually one of the obstacles we have to overcome in clinical trials in gene therapy is having outcomes that reflect in an quantifiable way what we are actually seeing in the patients. Standard measures may or may not reflect the benefits that the patients and families are receiving. And there are a few examples of this. One that happened at the very beginning of AB gene therapy was approved by the FDA.

Based on the ability to navigate a room in low light and this had never been used as an outcome before, but it was generated from the fact that this is what the patients was reporting and it was what she said was of value to them.

So those kinds of outcomes we need to be flexible about those and not ridged about what will define a benefit in each cases.

Mrs. Harshbarger. I totally agree. And I know I am over time. So with that, I

yield back.

Mr. Guthrie. The gentlelady yields back.

And the chair recognizes Ms. Trahan for 5 minutes for questions.

Mrs. Trahan. Well, thank you to the chair and to the ranking member for holding this important hearing. I am so grateful for the panel of experts here today. And I will give a special shout-out to Dr. Flotte from Umass Chan Medical School.

As the mother of two young daughters, it is great to see that many of the bills we are focusing will have a profound impact on the health of our kids. I am particularly grateful that the Accelerating Access to Care Act which I introduced with Congresswoman Mariannette Miller-Meeks is included in today's hearing.

Mr. Chairman, I would like to request unanimous consent to enter into the record a statement from the Children's Hospital Association in support of this bipartisan legislation.

Mr. Guthrie. We will add that to the documents list and take action at the end of the hearing.

Mrs. Trahan. Thank you, Mr. Chair.

When the necessary clinical care is determined for a child by medical professionals, there should about he no reason that administrative burdens get in the way. This Accelerating Kids' Access to Care Act is designed to cut through the red tape that kids get the appropriate care that they urgently need.

To express the importance of getting this legislation over the finish line, I would like to highlight a story from a patient who was negatively impacted by the burdensome and time consuming Medicaid provider screening and enrollment process.

Almost 3 careers ago, a baby and I will call her Lilly, was born in a rural State with

her esophagus in two different segments and connected abnormally to her windpipe. Because this condition requires a particularly complicated procedure to correct it doctors explained to the family that there are only two places in the country where it could be done.

One of them was Boston Children's Hospital in home State of Massachusetts. Immediately Lilly and her parents were ready to travel to Boston where the surgeons were ready to perform the lifesaving operation. But instead, Lilly, who is a Medicaid recipient was waiting for her home State to enroll the eight providers at Boston children's who needed to perform this complex surgery.

Her State confused about the rules concerning out of State provider enrollment would not authorize the services provided by Boston children's. Lillys surgery was rescheduled more than three times and delayed over 7 months. As Lilly waited she lived with a floppy airway that could have collapsed at any moment, a weakened immune system and routine breathing difficulty.

So Dr. Bassuk, while the process differs from State to State, can you please walk us through what it generally takes for a provider to enroll in another State's Medicaid program.

Dr. Bassuk. Yeah. So as I mentioned previously, it really does differ from State to State to the point that it feels like there are 50 different ways to do this. Iowa I think is sort of on the good side of things here, we work pretty fast. We can get someone enrolled in 30 days or less. I don't think it is fast enough for a kid like Lilly, that you mentioned.

But there are States because of fingerprinting, background -- criminal background checks, having to send in multiple forms of documentation where we have had 4 to

6-month waits.

Mrs. Trahan. Yeah.

Dr. Bassuk. And that is more than one, so it is not just one outlier. So unfortunately, the story that you tell is something that we deal with all the time.

Mrs. Trahan. And when you see a child in your practice who took a long time to get to the right level of expertise to treat the condition, what does that mean, not only for their health, but for the healthcare costs associated with that child?

Dr. Bassuk. There is no doubt that the healthcare costs are not just up for that child and the family but for the whole society. So I will give you -- like I said before, I have pages of these examples, but we will a baby in our neonatal intensive care unit, he was there for a long time. He is on out of State Medicaid.

That original State it was approved, but we figured out that he had a hearing problem and he needed to have a hearing test done and hearing aids put in. The out of State Medicaid said that he couldn't do it. So that baby actually missed developmental milestones that he may never make up.

That baby may have learning problems, that baby my not be able to work the way that that baby could have done because of this really just absolutely unnecessary delay. That has a huge financial -- that is not my expertise, but I think that we can probably agree that that is going to have a big financial impact.

Mrs. Trahan. And you spoke about this in your testimony. Beyond the child, how does this delay in care impact the well-being of the child's family?

Dr. Bassuk. So actually and Ms. Davis mentioned this as well, there is of course the suffering of seeing your child suffer, the anguish of them not getting care and the real financial cost.

If you have to move, you could have gone somewhere really close outside of your State but you have to go 4 hours away inside of your State and, you know, stay at a hotel and not work. It is financially and emotionally damaging.

Mrs. Trahan. With that, I urge my colleagues to support this bill.

And I yield back the balance of my time.

Mr. Guthrie. The gentlelady yields back.

And the chair recognizes Dr. Miller-Meeks for 5 minutes for questions.

Mrs. Miller-Meeks. Thank you, Chair Guthrie and I thank the witnesses for testifying before this subcommittee.

I am actually very grateful we are discussing these bills and I am pleased to see the committee considering as you just heard from Representative Trahan the Accelerating Kids' Access to Care Act which would streamline administrative processes for providers who enroll in another State's Medicaid program due to a lack of services provided in the patient's home State.

I am also proud to have a fellow Iowaian and constituent, Dr. Alex Bassuk. I too was on faculty at the University of Iowa, go hawks, here before the committee today.

There is currently no standardized Federal pathway for this process, meaning that providers must enroll in a new State's Medicaid program whenever they see a new patient from that State and must maintain regular paperwork to remain enrolled in each State's Medicaid program. And especially in Iowa with our four borders we have many people from different States who seek care in our home State.

When a child from a new State is visiting a doctor, as may be the case of a child from another State travels to Iowa for care, which is not unusual at all, there are often delays in care as the providers sift through weeks of paperwork, risking the health of

children with critical lifesaving conditions.

Mr. Chairman, I ask for unanimous consent to insert letters of support from the Leukemia & Lymphoma Society, which is undersigned by 215 organizations and from patients rising for Accelerating Kids' Access to Care and from a patients Senate in support of --

Mr. Guthrie. You submit those, we will add it to documents list and take action at the end of the hearing.

Mrs. Miller-Meeks. One case that clearly speaks to the need for this bill involves an 11-year-old from another Midwest State who has a very rare and serious condition known as midaortic syndrome in which the aorta narrows, leading to multiple serious complications that can result in death if untreated.

In this case, a referral was made from another children's hospital to Boston Children's Hospital which operates a leading program to address this condition and a comprehensive care plan was assembled in April of 2022.

In the case of the child's home State, all providers at Boston children needed to be enrolled in the home State's Medicaid program before the State would authorize the care. By July 2022 the enrollments were still pending, 3 months later, which led to a cancellation of care that had been scheduled for the following month, August 2022.

The home State did not complete its enrollment of the Boston children's providers until November of 2022. In early 2023, Boston children's assessed the child and a comprehensive care plan that included additional providers, given the child's specific condition was assembled.

A request for authorization was submitted in May of 2023 and the care was ultimately provided in September of 2023 nearly a year and half after the initial contact

had occurred and the child could easily have deceased before that time.

Dr. Bassuk, and I know you have answered some of this, in your capacity as a physician-in-chief at the University of Iowa's Stead Family Children's Hospital, have you seen the administrative burden in delays with providers enrolling in other State's Medicaid programs that impact pediatric care? And can you highlight specific barriers doctors currently face in this process?

I think you have so I am going to skip over that and say, does this legislation allow or require out of State Medicaid programs to cover services not covered by the patient's home State.

Dr. Bassuk. All right. So I will answer that second question. No, it absolutely doesn't require the home State to cover services that they don't cover. That is not what the bill is about at all. It is about making access easier for kids with medically complex and rare diseases.

Mrs. Miller-Meeks. And very importantly and similarly would this legislation lead to an increase in services provided or rather the same services provider but in a timelier manner?

Dr. Bassuk. Absolutely. It is about giving the right service in a timely service not different services.

Mrs. Miller-Meeks. And then lastly, very important as we are looking at CBO scores, do care delays increase cost to the healthcare system.

Dr. Bassuk. You know, in pediatrics we say, pay me now or pay more later so yes.

Mrs. Miller-Meeks. Thank you. Pay me now or pay me more later.

Dr. Chen, the ORPHAN Cures Act, which is again the same moniker, pay me now or

pay me more later, which I proudly cosponsor fixes the exemption from Medicare drug price negotiation to include treatments that are effective against more than one rare disease.

And in contrast to my colleagues, whatever research and innovation goes on, regardless of age group can be transferred to another age group. All that foundation of knowledge and science and innovation is transferrable, which also means that research that is done to the develop one drug to treat one disease may in fact find out that it treats another disease or a side effect that we didn't even realize.

So why is this legislation important for ensuring we continue to make progress in developing treatments and cures for more than 90 percent of rare disease patients that do not have FDA approved therapy.

Dr. Chen. So you want to take into account all of the potential indications a drug has of viability for. And some of those may be rare diseases, some of those might not be. And the bottom line is the entire pipeline matters.

Mrs. Miller-Meeks. And Ms. Davis, I had a question for you, but my time has run out, it is on small molecule medicines. Thank you so much for being here and the impact on IRA on research and development. I would like to submit the question to be answered.

Mr. Guthrie. Absolutely. Thank you.

Mrs. Miller-Meeks. Thank you. I yield back.

Mr. Guthrie. The gentlelady yields back.

And the chair recognizes Mr. Obernolte for 5 minutes.

Mr. Obernolte. Thank you very much to the chair and the witnesses. I think my microphone is malfunctioning here. All right technical difficulties resolved.

This is an unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker.

I would like to thank the chair and the committee for including my bill, H.R. 6020, the Honor Our Living Donors Act in this hearing. I introduced this along with my cosponsor, Congressman DelBene to solve a really important problem with the living owner donor reimbursement program.

I think the people in this room are probably not surprised to hear that we have currently over 92,000 Americans waiting for a kidney transplant. And yet, the number of living donors it was only about 6,000 last year and it is declining rather than increasing. That is a really serious problem.

So anything that we can do to incentivize an increase in the number of living donors I think is going to be something that not only saves lives but is service to a lot of people that are waiting it on that list. It is an incredible sacrifice to be an organ donor. And the impediments to being one are severe.

That is why Congress a few years ago authorized this living owner donor reimbursement program, which in a very modest way reimburses costs like travel expenses, dependent care, things of that nature for living donors. And by modest I mean the program is capped out at $6,000 per donor, it is modest. It is also means tested.

A donor or the recipient of the organ cannot have an income over 350 percent of the poverty line. This is a problem because it makes no sense to include the income of the recipient in this calculation. That has nothing to do with whether or not the organ donor is going to be able to make ends meet in donating the organ.

And so that is what this bill does, it makes that 350 percent means test apply only to the income of the donor, not to the recipient.

Another thing that the bill does is commission a study on the program to seek

ways that we can be more effective in both getting these donations funded and into communicating the existence of the program to the recipients. So I want to thank you very much, Mr. Chairman, for including that bill in this hearing. And I certainly hope that we can get speedy passage of that to fix this problem.

Dr. Bassuk, your testimony really interested me. And I wanted to talk about it with respect to organ donation. So recent studies have indicated that in addition to frequently needing organ donations, rare disease patients themselves can be living donors.

I mean, it is a misperception to think that they can't be, they can be and they have been very effectively. So could you talk about the importance of breaking down the barriers for rare disease patients to get care, including organ donation.

Dr. Bassuk. I think -- I mean, I will just reiterate what you said there, patients with rare disease, kids with rare disease need all the treatments that everybody else gets and the special treatments that they need as well. And they definitely should not be excluded from standard therapies.

Mr. Obernolte. Right. Thank you.

Ms. Davis, I think I am probably the last questioner you are hearing so I think it is appropriate to give you the last word. After considering everything that has been said in this hearing, if you could tell people one thing to take away from the hearing today what would it be?

Ms. Davis. Keep in mind that will take thousands of years at the current pace to reach treatments for all patients with rare conditions. That is unacceptable to me and I hope that it is unacceptable to all of you as well.

We know that the Orphan Drug Act is working. We have seen the great

incentivizations that it has provided in bringing novel therapies to patients in need. I urge you all to turn to those incentives, extend them and protect our orphan drugs from harmful policies that will restrict innovation and access to the treatments that can help our patients. Help our patients live better lives. Help our patients live longer lives. And help us have more days to spend and love our loved ones with rare conditions. Thank you.

Mr. Obernolte. Thank you for your testimony. And thank you to all of or witnesses for your valuable testimony today.

I yield back.

Mr. Guthrie. That concludes the members of the committee testimony. We do have one person that has asked to waive on from our full committee, so I will now had recognize Ms. Matsui from California, 5 minutes. And that will be the final witness.

Ms. Matsui. Thank you very much, Mr. Chairman. I want to thank you and the ranking member for holding this very important hearing.

Rare Disease Day is a time to raise awareness, celebrate our advancements and commit to building our progress. Ms. Davis, I have been moved bid your testimony.

As co-chair of the congressional Rare Disease Caucus, this is especially important to me. I am grateful to Representative Bilirakis, my co-chair for all of our bipartisan work on rare disease issues. And I am thrilled to see so many bipartisan bills noticed on today's agenda, including three bills I have introduced the BENEFIT Act. The RARE Act and the PROTECT Rare Act.

However, I am disappointed that this hearing has been highjacked by bills to dismantle the IRA. The IRA was a major step forward in ensuring Americans a clean bill of rare diseases. We don't have to choose between paying for their prescriptions and

basic necessities. This is especially frustrating when there are so many commonsense proposals to ensure rare disease patients have access to safe, effective and affordable therapies. I hope this committee can work together on these solutions rather than undermining the success of policies in the IRA.

I would like to turn to one such solution, the BENEFIT Act. In recent years, Congress' work with the FDA and patients has spurred the development of meaningful patient experience data being submitted to the FDA, including as part of new drug applications. One way of continuing this momentum is to ensure there is clarity around whether and how the FDA uses its patient experience data.

To address this gap, I introduced the BENEFIT Act to require FDA to describe how patient experience data was incorporated in the review process.

Dr. Flotte, can you comment on the importance of incorporating patient experience data into drug reviews?

Dr. Flotte. Thank you, Congressman. This -- it turns out to be an obstacle that we are facing right now in the development of several gene therapies for rare diseases.

We can compare patients who have disease with those who do not, but that does not always give us a clear-cut endpoint when we are seeing benefits from a treatment. And what could be more important than how that benefit is experienced by the patient and their families, particularly their parents.

The ability to get through, to get more drugs through the supply chain what families want. And if these treatments are actually producing benefits that are affecting patient experience, there has to be real validity.

Ms. Matsui. Right. Thank you.

Next I would like to turn to the RARE Act. I introduced the RARE Act with

Representative Bilirakis to codify long-standing FDA policy on orphan exclusively and ensure companies aren't gaming the system to keep new innovative therapies off the market.

Dr. Kesselheim, how would the RARE Act ensure continued development of additional therapies for rare diseases?

Dr. Kesselheim. Thank you. I think that the RARE Act is a very important bill because under the Eleventh Circuit decision that created this loophole in the Orphan Drug Act a manufacturer now can get a rare disease designation for a particular disease and then as that time is ending, get a new designation for a slightly different version or a slightly expanded population and through that additional 7 years prevent other competitors from coming on the market for the initial indication.

And in doing so create almost a perpetual state of market exclusively that would prevent the competition that would both lower prices for patients and help incentivize new discoveries of the future. So I think that the RARE Act is incredibly important to go back to the FDA's long-standing original interpretation of the Orphan Drug Act.

Ms. Matsui. Okay, thank you.

I now want to turn to another issue for rare disease patients affording their necessary medications. Over 90 percent of patients lack an FDA approved treatment for a rare disease, that is why I introduced the Protect Rare Act with Representative Dunn to ensure rare disease patients have access to medically necessary off label therapies.

To show how critical this can be I would like to share a story from one of my constituents. Janet was in her thirties raising her 6-year-old daughter when she was diagnosed with a rare and fatal disease called [indiscernible] despite her doctor's prescribed medications as the standard of care for her condition, her insurance wouldn't

cover these treatments because they were off label.

Rather than focusing on healing and spending time with her family, Janet was forced to fight for care while her symptoms and pain worsened and her finances suffered. I know I don't have much time here.

I will ask the question, Dr. Kesselheim, you know from your focus groups with rare disease patients that are struggling to afford necessary care is a common theme. How are the policies IRA ease the financial burdens of rare disease patients and their families? As I ask that question, I realize I have gone over so.

Mr. Guthrie. We will give you a few seconds.

Dr. Kesselheim. I think the IRA is extremely important to rare disease patients and their families because it helps promote fair prices for these products after these products have been on the market and fair prices help translate to better access to patients to the drugs that they need.

Ms. Matsui. Thank you very much. Thank you, Mr. Chairman.

Mr. Guthrie. The gentlelady yields back. And that concludes all member's questions.

I do say there are a lot of people in the room that represent families or people that have rare diseases or have children or family members with rare diseases.

Ms. Davis I know you were speaking for them today and we really appreciate your willingness to do so. That is how our loved ones lived on. We see it all the time here in Congress and it makes a difference. ALS bills were passed, different things have moved forward because of advocacy. Thank you all so much.

And Ms. Eshoo and I were talking about how wonderful the panel is and how good you guys are in representing what you do and we really appreciate that.

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So I do have a staff documents for the record list and that includes what Mr. Sarbanes, Dr. Schrier and Dr. Miller-Meeks brought forward. And I ask unanimous consent to insert in the record the documents included on the list.

Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

This is an unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker.

Mr. Guthrie. And I remind members that they have 10 business days to submit questions for the record. And I will ask the witnesses that they will respond promptly to the questions for the record. And members should submit their questions by the close of business on March 14. Without objection --

Ms. Eshoo. Mr. Chairman, I would like to respond to what you said earlier about CBO and Cures if I might. There is a December 2023 letter from CBO to Representatives Arrington and Burgess, Dr. Burgess from our committee, Mr. Arrington, the chairman of the House Budget Committee.

The letter was from CBO and it said that, "The share of venture capital reaching pharmaceutical companies has been trending upward" since the drug negotiation program was enacted. So I think that that is important. What I am presenting I think is important to be part of the record today, because I think this stands contrary what testimony has been given. So I thank you for giving me the time do so.

Mr. Guthrie. We know investments are coming and we want to all make sure that the rare diseases are included in that.

So thank you so much for being part of this subcommittee hearing this morning. And as I said, members submit their questions by close of business by March 14.

Without objection, the subcommittee is adjourned. Thanks a lot, thanks everybody for being here. Thank you.

[Whereupon, at 12:59 p.m., the subcommittee was adjourned.]