COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE
PUBLIC HEARING

STATE CAPITOL
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TUESDAY, FEBRUARY 25, 2020
9:36 A.M.

PRESENTATION ON
PRESCRIPTION DRUG PRICING

BEFORE:
HONORABLE KATHY L. RAPP, MAJORITY CHAIRWOMAN
HONORABLE VALERIE S. GAYDOS
HONORABLE MARCIA M. HAHN
HONORABLE JOHNATHAN D. HERSHEY
HONORABLE AARON D. KAUFER
HONORABLE DAWN W. KEEFER
HONORABLE CLINT OWLETT
HONORABLE BRAD ROAE
HONORABLE PAUL SCHEMEL
HONORABLE DAVID H. ZIMMERMAN
HONORABLE DAN FRANKEL, DEMOCRATIC CHAIRMAN
HONORABLE MARY JO DALEY
HONORABLE PAMELA A. DELISSIO
HONORABLE ELIZABETH FIEDLER
HONORABLE SARA INNAMORATO
HONORABLE MICHAEL H. SCHLOSSBERG

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Pennsylvania House of Representatives
Commonwealth of Pennsylvania

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I N D E X

TESTIFIERS

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SUBMITTED WRITTEN TESTIMONY

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(See submitted written testimony and handouts online.)

P R O C E E D I N G S

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MAJORITY CHAIRWOMAN RAPP: Members of the public, thank you for being here today. Due to a lot of concerns that we hear across the Commonwealth from our constituents, this is a hearing in regard to the price of prescription drugs, the cost of those drugs. And obviously, this seems to have drawn a lot of interest from the public.

We are in the process of having TV downstairs because I believe it is against regulations to have everybody standing in the hearing room. So, this informational hearing is going to be live-streamed, so we're working on that. Do you know if a video crew has our TVs -- okay. They are setting one up upstairs or downstairs in the lobby. So, if you can find -- there are a couple Chairs right over there. These Chairs here are for our testifiers. But I know security was just here, but there is a problem having everyone standing here.

But I'd like to welcome you and thank you for your interest. As I just stated, we know this is a big concern for our constituents across the State of Pennsylvania.

I am Representative Kathy Rapp. I am the Chairman of the Health Committee, and I am from Warren County, the 65th Legislative District, and I represent all

of Warren County, half of Forest County, and parts of Crawford.

And at this time I will have the Members, starting with Chairman Frankel and going to my right, please introduce yourselves.

DEMOCRATIC CHAIRMAN FRANKEL: Representative Dan Frankel from Allegheny County, city of Pittsburgh, Democratic Chair of the Health Committee.

REPRESENTATIVE ROAE: Representative Brad Roae. I represent most of Crawford County and parts of western Erie County.

REPRESENTATIVE HERSHEY: Representative John Hershey from Juniata and Mifflin Counties.

REPRESENTATIVE KAUFER: Aaron Kaufer, 120th District, Luzerne County.

REPRESENTATIVE HAHN: Marcia Hahn, 138th District, Northampton County.

REPRESENTATIVE FIEDLER: Representative Elizabeth Fiedler, south Philadelphia, 184.

REPRESENTATIVE SCHLOSSBERG: Good morning. Representative Mike Schlossberg, Lehigh County, city of Allentown, and South Whitehall Township.

REPRESENTATIVE OWLETT: Representative Clint Owlett, and I serve in the 68th District, which is all of Tioga County, parts of Bradford, and parts of Potter

County.

REPRESENTATIVE SCHEMEL: Paul Schemel, I represent a portion of Franklin County.

REPRESENTATIVE INNAMORATO: Sara Innamorato, city of Pittsburgh and northern Allegheny County.

REPRESENTATIVE DALEY: Good morning. Mary Jo Daley, Montgomery County, collar area of Philadelphia.

REPRESENTATIVE DELISSIO: Good morning. Pam DeLissio, I represent the 194th, parts of Philadelphia and Montgomery Counties.

MAJORITY CHAIRWOMAN RAPP: Thank you, Members and staff, for being here today for the public's interest. There is also appropriation hearings going on today, so some of our Members, if you see them exit, it is because they also serve on the Appropriations Committee.

I would ask you also at this time to please silence your cell phone. This information hearing is being recorded, and it is also, again, being live-streamed.

So, at this point I don't want to take any more time away from our testifiers. And our first testifier, welcome, sir. This is Antonio -- I apologize. I'm not going to pronounce your name right. I'll let you --

MR. CIACCIA: The last name is Ciaccia.

MAJORITY CHAIRWOMAN RAPP: Okay. And you are the CEO of 46 Brooklyn. And so at this point in time are you

prepared to go ahead, sir?

MR. CIACCIA: Yes, absolutely. I appreciate it very much. Can you all hear me fine?

MAJORITY CHAIRWOMAN RAPP: Yes.

MR. CIACCIA: Excellent. I apologize I'm not there in person. My wife is due with our third child here in the next week or so, so I was on a no-fly list for this week.

It's a treat to speak with you. My entire family is from Pennsylvania, Aliquippa, Beaver County, Centre Township, Monaca, Moon Township, Bensalem, so it's a real treat, so thank you very much.

I will get my slides up here. You can see these fine, correct? Excellent.

So, my background, just to give you a little bit of an overview, for about a decade I've worked for the Ohio Pharmacists Association. In my time at the Pharmacists Association, I learned that prescription drug pricing is extremely complicated. I still do some work part-time for the Pharmacists Association, so it's an important disclosure there.

I'll give you a little bit of a background as to what 46 Brooklyn is and what my consulting firm 3 Axis Advisors is. And it's not a sales pitch by any stretch, but it gives you a good background for why I know what I

know and why I know what I don't know.

46 Brooklyn Research is a 501(c)(3) nonprofit that we launched in August 2018. Our job is to make drug pricing data more accessible and understandable to the public. In my time working in pharmacy, all I hear about is drug prices are too high, we're spending too much, but I learned very quickly in my time at the Pharmacists Association the nobody knows how prices are set, and nobody understands how essentially those prices end up manifesting their way through the supply chain. So, we try to take publicly available data and create drug pricing visualizations to help other people understand how the system works.

We figured that publishing this data would be interesting to maybe nerds and that would be about it. When we launched the website and we started publishing all of our drug pricing chart, we started getting inundated with employers, foundations, researchers who all wanted to use us to help inform their work to try and tame the beast of drug pricing as well. So, we didn't want to do it, but we had a lot of inquiries to do it. So, now our consulting firm 3 Axis Advisors, rather than working with publicly available data, we actually work with plan sponsors, employers, pharmacy groups, benefits consultants, law firms, foundations, and even a Medicare Part D plan to

analyze their drug pricing or at least what they're being charged for prescription drug prices.

So, my road into this at the Pharmacists Association, I've had pharmacists complaining that they weren't being reimbursed well through the Medicaid Managed Care program any longer. Specifically, overnight pharmacies saw a cut of 60 to 80 percent in their gross margin within the Medicaid Managed Care program in Ohio. Regardless of whether pharmacists get paid enough, too much, too little, doesn't matter. To me, it was very interesting that they saw this massive swing in their reimbursements seemingly overnight.

So, I went back to the State of Ohio Medicaid program thinking that I had dropped the ball, and so I asked them if they changed anything. Was there a policy change, or were they just cutting rates? And he said no, they were paying more than they ever had. So, that inspired me to start doing some digging into data that we haven't really looked at before because my frustration with pharmacists was, years ago, when I started doing government affairs for them was that they would walk in with all these screenshots of underpayments from pharmacy benefit managers or PBMs, and they would say, look, you know, I'm not getting paid enough, but, you know, they would give me these receipts and their pharmacy would still be open and

they would be losing $300, $400 a claim sometimes, at least what they were showing me. And it didn't make sense to me that somehow these businesses were still viable.

Well, sure enough, I start asking them questions, and they're making $300, $400 on some claims. And since a pharmacy generally needs about $10 just to break even in margin, a $300 underpayment and a $300 overpayment made no sense to me. And so I was very curious how drug prices were being set at that point.

So, two years of learning and digging eventually in Ohio led to uncovering hundreds of millions of dollars in the Ohio Medicaid program in hidden drug costs. We essentially were able to discover what's typically referred to as spread pricing where a PBM will pay a pharmacy one rates, and they will bill a different rate back to the plan sponsor, in this case, the Medicaid Managed Care program and the PBM pockets the difference. It's not an inherently wrong thing, but it is an unaccounted-for line item that could add hundreds of millions of dollars into generic drug spending, which we as a society highly rely on in order to balance the books on drug costs.

So, we launched 46 Brooklyn to publish and translate publicly available drug pricing to the public, and we launched our consulting firm to help others with their other proprietary data needs.

So, just to kind of set the table, the United States spends more on health care than really almost any other country in the world, and we have some of the worst outcomes for it. And so the reason I say this is because typically, in my experience working with members of the drug supply chain, they love to get into aggregate numbers. And on the aggregate, you know, so-and-so is saving money or on the aggregate we're doing great or in the aggregate we're doing poor. Aggregate numbers hide the details of how the sausage is made. And at the highest aggregate level the United States is terrible in terms of health care spending efficiency. And so our job, we feel at least in the drug space, is to help give as much detail as possible to see how the drug expenditures might be contributing to that.

So, the first question is are drug costs truly unsustainable? We analyzed drug prices. We use a database called Medi-Span, which is very much the industry standard for tracking drug prices, and those are list prices. And if you're looking at list prices, it seems that while the brand-name drugs are growing and they're rising, they are not rising as much as they used to. That's interesting only because typically, when we talk about the fervor over drug pricing, usually the headlines that you see in the media are about list prices. The problem is is that nobody

actually pays list prices. So, what we're seeing in the data is that drug price increases are slowing, but those are list prices.

So, what's happening to the next prices? Most people don't know this, but the list price of a prescription drug is typically not what many people actually end up paying. Drug manufacturers, for the purposes of trying to secure positioning on an insurance company or a PBM's formulary, will offer price concessions or what's typically referred to as rebates to offset the cost of the list price of the drug.

And what we're seeing is that that rebate or that aggregate amount of discounts that drug makers are giving back to insurers, Medicaid programs, and PBMs, they're growing significantly over time, typically referred to as the gross-to-net bubble. That difference between the list price and what essentially drug makers net out in revenue has actually reached about $166 billion in 2018. That's the last, you know, large-scale analysis of those rebates. So, when you're talking about drug prices increasing, it's important to track the price, but it's also important to track the other end of the spectrum, which is how much concessions and discounts are being passed back through the system.

So, this chart shows essentially how much those

increases are occurring over time, so back in 2013 the amount of aggregate rebates and discounts that drug makers offered was $83 billion, and they have since doubled in 2018 to $166 billion. So, there's a tremendous amount of savings to be had on these prescription drugs, at least brand-name drugs.

So, here's a piece from the *Wall Street Journal* that ran just last year where they were analyzing rising prices versus what the actual market clearing rate was, and what they found was that drug prices after the discounts, which, again, are known as rebates, are actually going down.

So, in our research we typically refer to rebates as money from sick people. And the reason is is because a lot of people end up being exposed to paying some of the sticker prices on these drugs, but those rebates are garnered by PBMs and insurance companies based on utilization trends. So, the more that a sick consumer enters the marketplace or the more drugs that a sick consumer purchases, if they're getting these high, expensive, brand-name drugs, the more rebates that means for the PBMs and the insurance companies.

Now, some of those rebates end up getting passed through and lowering premiums, but not all of those concessions do. So, this is just another way to see that

rebates have a significant impact on distorting what the true price of drugs are. And it's true for the commercial sector, it's true for Medicaid, and it's true for Medicare Part D.

When you think of rebates, I tell people to think of it as price discrimination, which sounds more insidious than probably people would like, but it's the truth. If the list price of something is $100, State Medicaid programs, by virtue of mandated discounts, typically will receive the best price. So, what you'll see at the bottom of this, you know, heat chart is that Medicaid programs typically pay the lowest amount off of that list price. And then you have big-four government payers that pay a slightly larger chunk of that price. You have Part D plans that will pay a slightly larger portion of that, and then you'll have large employers that have a much larger exposure to list price. And then you have patients that are in pre-deductible phases. Or when you have small employers that have very little leverage in negotiating power, they typically end up getting exposed to the most of that list price.

So, those who understand the game or those who have the most negotiating power, especially governments, they get the most benefit out of those rebates. And so when you think of rebates, think of essentially inequity in

payments. I'm not saying it's inherently bad or good. I personally feel that I don't like the way that the system yields winners and losers. But at an aggregate level most people will tell you, well, the drug pricing problem isn't as bad as it used to be or, at a net level, PBMs are controlling costs. Yes, in the aggregate, all of those things could be true, but lost in that aggregate number is the very real side effect that there are winners and losers in terms of who is paying the bill.

So, here's just one case study. Advair, it's a very popular inhaler, this was from Axios in April of 2019. One of the largest PBMs in the marketplace, Express Scripts, requires pharmacies to dispense brand-name versions of Advair instead of their generic equivalents. Well, part of the rationale for that is that from Express Scripts' perspective, they get enough rebates in the aggregate for it to essentially make the most dollars and cents for them to grab those rebates, and then they get to determine which plan sponsors will be the beneficiaries of those rebates that they collect.

So, Advair could be available at a 70 percent discount, meaning Express Scripts could get a 70 percent rebate from the manufacturer GlaxoSmithKline. It is then up to Express Scripts to decide how much if any of that rebate they want to pass along back to their clients. So,

back to the chart that we have showed before, it stands to reason that if Express Scripts is doing this for Medicaid programs, they're likely passing some of those savings through, but for a small employer or a patient in their deductible phase, they're being exposed to more of that list price, essentially not getting that 70 percent discount. And I'm offering that as a hypothetical. I don't have actual data on that in front of me, but I do it for illustrative purposes on how the system works.

So, one of our first clients that we did data analytics for was a benefits broker group that does drug pricing research, and they offer expertise to small employers. And what we did is we looked at what was happening to the rebates on the Federal supply schedule. Essentially, the Federal Government, the rebates that they get, we compared them to what the smaller employer group was getting.

We found, again, is this massive inequity between the haves and the have-nots. While the Federal supply schedule, if you took their drug utilization and applied it to the rebates that they were getting, it would have been about $30 million the small employer group would have had if they had the negotiating power and the prowess of the Federal supply schedule.

But instead, because they're not in on the game,

because they don't have the negotiating power, they only received $5 million of the rebates that were on the table. So, what's happening is, as those list prices are increasing and the rebates that are being passed through the system are also increasing, the problem of inequity actually gets worse and worse over time for the have-nots.

So, the question is, you know, are brand drug costs going up or down? It's very, very complicated. Because all of this data is ultimately proprietary and because it lives below the surface of these aggregate reports, there are people that will come to you as lawmakers and say we're having a hard time controlling our drug spending, but there are others that will not have this problem. And so it's very, very hard to know, because of the discounts that cloud the system, what a fair price for a brand drug is. But that's not necessarily the case for generic drugs.

So, here's how the system is supposed to work. We as Americans want new drugs and innovation. Drug patents that we give to manufacturers give them the ability to set prices, and thus, manufacturers have the incentive to bring new drugs into the marketplace. We as Americans grant those manufacturers those patents with a catch, that eventually that patent exclusivity will expire, and when that patent expires, it enables generic manufacturers to

enter the market to bring competing versions of the brand drug into the marketplace.

By opening the door to new manufacturers, competition should drive prices down, and it typically does. In order for brand manufacturers to create new revenue opportunities for themselves, it's incumbent upon them to bring new drugs to market and replenish the pipeline. So, hopefully, that incentive brings new drugs to market. They lose their patent. In order to make more money they bring others into the marketplace hopefully keeping the churn of innovation.

Increasing prices of brand drugs should be offset to a significant degree by the deflation that the generic drug marketplace provides. That's how the system is supposed to work. And here's how it actually works. Many of the new drugs that are brought to market by drug manufacturers are slightly modified versions of old drugs. The drug companies can use rebates to entice PBMs and insurance companies to cover more expensive drugs that have negligible added benefits to the system. Those rebates drive drug companies to raise list prices higher than they otherwise would have without having to give the rebate. And drug makers can use patent thickets that can delay generic competition.

After patent exclusivity, the door opens for new

manufacturers to enter the market, and they do, and that competition usually does work to drive generic drug prices down. However, most payers are charged rates by insurance companies and PBMs not based on the actual cost of drugs but instead based on unrelated inflated sticker prices.

Unfortunately -- and this is what our research bears out in Medicare Part D, in the Medicaid programs, and the commercial sector -- the benefits of generic drug deflation do not end up getting passed in their entirety onto payers, and this has a huge impact on inflating overall drug spending.

So, the question is if generic drugs are actually going down in price, why aren't payers or plan sponsors actually being shown those savings? Here's an example in the State of Pennsylvania. So, this is from our 46 Brooklyn website where we track national average drug acquisition costs, which are surveyed invoice prices that pharmacies report to CMS on the cost that they pay to acquire their drugs before they get any of their own rebates and concessions from the wholesalers that they purchased them from. That's the blue line. The orange line is a quarterly breakdown of what the Medicaid Managed Care program in the State of Pennsylvania is being essentially charged for those same drugs.

This drug is generic Gleevec. It is a leukemia

drug. The actual market clearing price of that drug or the NADAC decreased 95 percent from the second quarter of 2016 to the second quarter of 2019, so a significant amount of deflation the market was working. However, the rate that the State of Pennsylvania was being charged increased by over 18,000 percent over the same time period. That is the orange line.

So, at some point this difference between the orange line and the red line is a shared margin between the pharmacy and the PBM. The only difference between the pharmacy and the PBM is that it's the PBM that gets to set the price of the orange line. So, at some point the markup on that drug was pennies on the dollar. And, over time, it increased to over $105 per pill.

So, this is the data crumb trail that we ultimately followed in the State of Ohio. As pharmacies were complaining that they weren't making enough money in the Medicaid Managed Care program, as I said, on the other end of the spectrum the State Medicaid program was paying more than they ever had. We showed lawmakers and State Auditor Dave Yost all these charts that we showed you before for the State of Ohio, and ultimately, they said there's a problem here.

So, the Auditor opened the books and ultimately found that there was a massive gap that was growing over

time between the rates of what were actually being paid to pharmacies and then billed back to the States. That audit revealed that $244 million in spread pricing was being captured by PBMs within the Medicaid Managed Care program over the course of just one year. This amounted to about $6 per prescription, which, according to the Medicaid analyst who studied this, said it was three to six times the going rate for typical PBM services. So, the cost of generic drugs were in fact going down, but the PBMs and really the drug supply chain as a whole was not passing the savings back on to the State.

And the reason this was occurring is because plan sponsors, whether it's Medicaid Managed Care programs, commercial employers, or Medicare Part D plans, are not paying for generic costs based on actual market-clearing rates of those drugs. So, in an inflationary market you want to actually pay based on the real cost of the drug, not an inflated sticker price.

What this chart shows you is that the blue line shows what is happening in the aggregate on generic drug prices on a per-unit basis. So, if you took all the generic drugs in the marketplace and threw them into one bucket, what you see in the blue line is that, in the aggregate, generic drug costs are in fact going down over time, but because State Medicaid programs, commercial

plans, et cetera, are not paying based on true pricing, they're being charged based on list prices, which is average wholesale price. That's the red line. That's the sticker price.

So, while actual drug costs, generic drug costs are going down over time, if you look at the list prices of those same drugs, they're increasing significantly over time. The price that you're being exposed to typically as those that are paying the bill is the red line, not the blue line.

So, ultimately, the system is built on what we call bogus pricing benchmarks because they're not reflective of true, actual market-clearing rates. And if you listen to insurance companies and PBMs, they will tell you this in their SEC filings and in their 10Ks. They are completely reliant on average wholesale price as a backbone of their contracts that they have with their payers. This is from Cigna's 10K. Here's one from CVS Health also saying their reliance on average wholesale price to set prices in the marketplace.

Because AWP or list prices have little relation to actual drug costs, this is what provides the opportunity for members of the supply chain to capitalize on arbitrage. You have a known price that is not inserted into the equation, and so when the system relies on bogus prices,

that's where all the games can be played.

So, here's the fallout of using these bogus pricing benchmarks. This is the Medicare Part D program. Every little line on these charts represents what each insurance company or Medicare Part D plan is reporting back to CMS as the cost of a specific drug. This drug on the top is generic Abilify, which is one of the most popular drugs out there. What you see here in very, very small lettering is that the actual NADAC price or the typical pharmacy acquisition price for this drug is 26 cents per pill. What this chart shows is that plans are paying anywhere from that rate all the way up to nearly $20 per pill. The distribution of the rates that the plans are being charged are all over the map.

The chart underneath that is generic Gleevec. Again, that's that leukemia drug I mentioned before. Here the NADAC price or the actual price for pharmacies to acquire the drug is $14.36. What you see here is that there are plans are paying anywhere from $12 per pill all the way up to more than $300 per pill. This is all over the same time period, the first quarter of 2019. That was Medicare Part D.

This is the State Medicaid programs. This is vitamin D cream, generic Dovonex. This is a manmade form of vitamin D. What you see here is that the actual NADAC

price of this is $1.57 per unit. That's the cost it takes for pharmacies to acquire the drug. What you see on this map is the different rates that are being charged to Medicaid Managed Care plans in every State across the country. You see a $1.34 in the State of Iowa. You see $4.16 in Florida, $2.49 in Pennsylvania. Pennsylvania is actually getting a relatively speaking better price than other States.

What you see here is that over the same time period, this drug is $1.57 per unit for pharmacies to acquire, and the pharmacies generally get paid very similar rates across the board. But what you see is that the end payer is not getting exposed to anywhere close to that market-clearing rate.

Our most recent project that we did is we did a public records request of the State of Florida where they actually gave us claim-level detail of what every pharmacy in the State was essentially being paid on a per-claim basis, so every drug in the marketplace going back to the year 2012 we were able to see what the State was being charged pharmacy by pharmacy, drug by drug, insurance company by insurance company.

And this is the exact same drug where the price is just under $2 per unit, and what you see is one health plan, the price is a buck 51. Another health plan is

$2.72, $3.19, $3.89, $4.44, $6.58. The gray line here shows the number of prescriptions that were dispensed in this system under this pricing structure. And surprise, surprise, the plan that had the most expensive pricing on this drug saw the most prescriptions dispensed. So, what we believe happened was that PBMs and insurance companies were overpaying pharmacies on these particular drugs, and pharmacies in the State of Florida, seeking margin, actively went out to try and chase as many of those overpriced prescriptions as they can. And so this is the fallout of that.

Just to give you an idea of how profitable this vitamin D cream was for pharmacies in the State of Florida, we found one pharmacy called MedZDirect, which dispensed an overwhelmingly disproportionate share of the calcipotriene cream or vitamin D cream in the State. They made $1.8 million alone in one year on the dispensing of generic calcipotriene cream.

To give you an idea of how screwed up that is, that margin that this pharmacy made on one drug was equivalent to all the margin that community pharmacies made on all generic drugs for 980 pharmacies. So, 980 pharmacies' worth of quote/unquote profit was equal to all the profit that MedZDirect made on just calcipotriene cream.

Now, shame on MedZDirect for going out and chasing that margin, but my pushback to lawmakers on this is, look, the pharmacy doesn't create the incentive. The PBM ultimately determines what they will pay from drug to drug to drug. And so the PBM actually chose to set that price absurdly high, which is what we show in the previous chart, and so the pharmacy, seeing where the incentive was, went out and grabbed it. So, when you have pricing benchmarks that aren't based on real prices, this is the fallout. It's not just PBMs that can overcharge you. It's pharmacies who can take advantage of the incentives that PBMs and insurers push into the system to increase the cost for the State.

So, here's a breakdown of how this looks with sticker prices on generic drugs. So, the sticker prices, as I mentioned, on generic drugs bear no relation to the actual cost of these drugs. And what each one of these dots represents is what every insurance plan essentially guaranteed as an aggregate discount off of those list prices to a group of commercial payers that we analyzed. What you see again here is that, plan to plan in the commercial sector, the rate that the insurance companies and PBMs are delivering back to commercial payers is all over the map.

Here are a few drugs that we picked out that

shows you the pricing differentials from plan to plan across all of these commercial payers. So, all of these are the exact same drugs dispensed over the exact same time period. The star equals the NADAC or what the actual price of the drug is, and what you see is is that the prices that the payers are being exposed to, they're almost no relation or no consistency whatsoever back to the actual cost of that drug.

The same thing is happening in the TRICARE program federally, so for our armed services, prices that are all over the map on a drug-by-drug basis, month-by-month basis.

Here is some data from our Florida project that just came out. This is the Centene plan. Centene is a very large Medicaid Managed Care program in the State of Florida and States across the country. What we found here was that Centene signed up for CVS Caremark as their PBM midway through 2017, meaning that CVS Caremark acting as the PBM was able to set prices in the pharmacy marketplace starting midway through 2017. So, Caremark -- most of you know CVS is the pharmacies but don't know Caremark as the PBM.

What you see here is that when CVS Caremark got to set prices once they took over PBM services for Centene that all of a sudden the payments on some drugs all of a

sudden collapsed for grocery store pharmacies and independent pharmacies, but all of a sudden the rates that were being reported back through the State Medicaid program for CVS pharmacies shot through the roof. So, CVS Caremark got the keys to control where the money goes within the Centene plan in Florida.

What we found was that overall in 2018, 94 percent of all the margin that was paid out of generic drug claims in the pharmacy marketplace was reported on claims that were dispensed as CVS pharmacies.

This drug in this chart is generic Abilify where we show that when CVS Caremark took over acting as the PBM or the price setter for Centene, all of a sudden the rates paid to competing pharmacies to CVS Pharmacy fell through the floor, and the rates that were being reported at CVS Pharmacies skyrocketed.

So, back to Ohio, how did we figure out what was going on in this system in the first place? What we found is that the State was paying about 20 percent more per member per month on prescribed drugs within the Medicaid Managed Care program from 2015 to 2017. Now, what's interesting to us because over that time period is when we saw all the margin of attrition occurring at the pharmacy marketplace.

We ended up asking for an itemized receipt for a

breakdown of where the per-member, per-month rates were being influenced the most, and what we found was that in a period of significant generic drug deflation the State of Ohio actually saw increasing costs on a per-unit basis on generic drugs. That was our canary in the coal mine that perhaps there was being some gaming done on generic drug prices.

It was at that moment when I walked through the doors of *The Columbus Dispatch*, shoutout to local journalism. I walked in with our charts and I said, look, I think that there's a problem here. We're seeing issues with underpayments to pharmacies but big-time increases in what the State is investing in the drug spend. I walked out of my first meeting with them, and they said we think that there will be two or three big articles that we can make out of it. They have since written 160 articles, podcasts, letters, and editorials, all dedicated to uncovering what's happening in the prescription drug supply chain and how PBMs set prices in the system.

The Dispatch's relentless coverage here in Ohio forced the Department of Medicaid to end up performing its own audit. As I mentioned, the State Auditor ended up opening the books to the Medicaid Managed Care program. They found $244 million of hidden spread pricing revenue that was being pulled out of the system by PBMs. This

equated to 31 percent markup on all generic drugs that were dispensed to the Medicaid program.

So, since then, this has really kind of snowballed outside of Ohio, so there are States across the country that are now doing their own audits. There are States that are now banning spread pricing. All of those things certainly add clarity into the system, but they don't actually attack the root problem, and that is our reliance on those bogus pricing benchmarks. So, in Ohio they ended up instituting full transparency requirements in the Medicaid Managed Care program, and they banned spread pricing. So, the question is if PBMs were making $244 million off of this line item before, where were they essentially moving to make that money after the fact?

So, we did data analytics in Michigan, and they also banned spread pricing in 2018. What we found is that when the State banned spread pricing, all of a sudden payments to pharmacies exploded. We saw huge increases in the rates that were being paid to pharmacies, so the pharmacies were quite happy at first, but then they realized that, rather than the PBM paying the pharmacy one rate and billing a different rate back to the plan sponsor, what they did is they changed their contracts to pay the pharmacy one rate, bill that same rate back to the plan sponsor of the Medicaid program, but then claw back the

money after the fact when the money was essentially out of the visibility of the plan sponsor.

MAJORITY CHAIRWOMAN RAPP: Antonio, this is --

MR. CIACCIA: Yes.

MAJORITY CHAIRWOMAN RAPP: -- Chairman Rapp, and we have a couple other speakers that we need to get to. And our next presenter has an appointment that she has to leave I think at 11:00. Can you hang on for questions at the end or do you want to give us a --

MR. CIACCIA: I would be more than happy to do so, yes.

MAJORITY CHAIRWOMAN RAPP: Okay. Thank you so much. Then we'll get back to you.

MR. CIACCIA: Okay, great.

MAJORITY CHAIRWOMAN RAPP: And very interesting. Thank you so very much. And if you can hold on for questions at the end, we'd love to hear more from you.

MR. CIACCIA: You got it.

MAJORITY CHAIRWOMAN RAPP: Very interesting. Thank you. Thank you for all the handouts.

So, our next presenters -- and before I introduce Janet Horvath -- Janet, just hold on for a second -- I'd like to recognize Representative Dawn Keefer and Representative Dave Zimmerman. Anybody else that came in during introductions? Okay.

So, our next presenter is Jane Horvath. Jane, thank you for being here. Jane is the Senior Policy Fellow at the National Academy for the State Health Policy. And, Janet, whenever you're ready, please proceed.

MS. HORVATH: So, thank you very much for the opportunity to be here today, Chairwoman and Chairman. I actually don't work at the National Academy for State Health Policy. I left there in 2018, and I have foundation funding and other support to work with States and advocacy organizations on prescription drug cost policy. Okay. So, I apologize for that error.

I think what I'm going to do is set my testimony aside other than to make a couple points about it and then zero in on a lot of what we heard this morning and thinking about it as policymakers if that's okay and then you can get back on track.

But I did want to say that, first off, nobody's walking with God in this industry. I mean, you know, it is just a highly dysfunctional marketplace on so many levels, as we've just heard. And I'm not going to repeat any of that. But there are deep, deep problems. There are deep, deep problems in the generic industry, and those are separate from the deep, deep problems of the brand industry. And, again, there's enough going on to point fingers every which way, which is the problem for

policymakers.

And, as State policymakers in particular, you know, I've worked with a number of States now in a different capacity than Anthony, but back of the envelope, most States, their tax revenues support the pharmacy benefits or support the pharmacy services of about 25 percent of the State population, so that's a huge stake of State residents and you as policymakers responsible for the fisc of the State. You know, that's Medicaid, that's prisons, that's university employees and retirees, State employees and retirees. It just goes down the list. And I'm sure Pennsylvania is probably right in that main.

So, I have spent a good deal of time, over a decade, in the brand industry itself. I worked for Merck and did some consulting for biopharma, and I've always been concerned about prices. And it's become clear to me that even the players that want to do different, they can't do different. They can't step out. And so there's a role for public policy in this space.

I also think that the problems start with high prices, and I understand why, as Anthony has said, why prices are getting higher and higher, the gross-to-net bubble. That is all very real. But all of this started with high prices and sort of all the machinations that have built up around manufacturer high pricing to try to deal

with it. And I'd say it's all a little out of control at this point from soup to nuts.

And there's reasons why manufacturers want to maintain their ability to price, you know, have just sort of unfettered ability to price, which is what they do in the U.S. market today. I think they need a high U.S. price for purposes of international reference pricing, which many other countries do. And they also just -- you know, no industry likes to have their ability to set their prices regulated.

But I will say that the traditional role of States has been protecting the health, safety, and welfare of their residents. And States have stepped in since the early 1900s to regulate industries with high dysfunction or the potential for high dysfunction when there is the opportunity for monopoly pricing and where State resident health and safety is at risk. And I think that this is similar here.

And I think one of the ways to think about this is for State policymakers to consider ways of creating transparency in the whole supply chain starting with the price that the manufacturers set and then making sure that there is absolute transparency throughout the whole thing so that some of these machinations that we see can't happen.

And in my testimony I do talk about a prescription drug affordability board. I've talked about all different ways that States are trying to create transparency and manage the problem here. But in my years I really think that the solution at least at the State level until we can get some good Federal action going here would be a prescription board of a certain -- you know, you can set it up different ways, but it totally mirrors what States have done for 120 years now on public utilities.

And once what the consumer will pay is established, then everything else falls in line. And, you know, you don't have the profit-taking on the drugs from the insurance industry or the PBMs or the pharmacies. It's also a way -- one of the key pieces of dysfunction in this market is that everybody makes money off of the price. I mean, that's how it's done, and that's why, you know, we get to this situation.

Even back to academic research institutions who do the bench science, the lab coat science that develops the molecule that looks like it might help somebody, then they license it, they patent it, the academic institutions, and then they'll sell it to Pfizer or Merck and they'll collect royalties on it. And so they, even going all the way back there, have an interest in high drug prices, you know. And the wholesaler has an interest in high drug

prices, but I think less. They make their money more on sort of volume.

The PBMs, the health insurance are just trying to stay afloat by getting these rebates and trying to keep premiums down. That's a really important thing, and the health insurance industry, as you know, making premiums affordable so that your risk pool is stable and all of that, so all rebates don't go to consumers. They do go to premium stabilization.

What else did I want to say here? Oh, you know, just -- so I also think that we're seeing a huge problem with launch prices. You know, launch prices of new drugs, new, really important drugs are going up and up and up. There seems to be no limits on the ability of manufacturers. We have chronic disease meds that people who are going to take them for the rest of their lives, they start out at $300,000 or $400,000 a year, you know, and they're not necessarily tiny populations. And so, again, we really have to think about this in a comprehensive manner because there is just these systemic problems.

Anyway, I guess that's really the guts of what I wanted to say. And one more thing was that I think, as policymakers, you need to focus on affordability and not product value because that's what's missing here in this

discussion is what's affordable. What's affordable for the patients, Medicaid program, insurers, State employees. What's affordable? And affordable means what's affordable so that every patient who needs that drug, you know, is indicated for that drug can get that drug, which would ultimately mean more sales for manufacturers than they get now because their drugs are so high-priced. Everybody who needs the drug doesn't get it, so sort of, you know, more affordable cost and more utilization and more transparency. And I would say leave the value equation to clinicians and doctors.

That's really it.

MAJORITY CHAIRWOMAN RAPP: Thank you very much. I understand that you do have to leave shortly. Could you take a few questions?

MS. HORVATH: Yes, I have to catch a plane. I have to leave here, end of time 11 o'clock, so --

MAJORITY CHAIRWOMAN RAPP: And we're time-constrained, too.

MS. HORVATH: I know. I know.

MAJORITY CHAIRWOMAN RAPP: Chairman Frankel, did you have anything?

DEMOCRATIC CHAIRMAN FRANKEL: Yes. First of all, thank you, Jane. I've had the opportunity to meet with you on a number of occasions, and the concept of a

pharmaceutical affordability board is something that I've been exploring and have introduced legislation with respect to.

Let me ask you, first of all, maybe you can give us a quick rundown. I mean, one of the key items that I take from the legislation that's modeled after your model that is now in place in Maryland is this issue of almost like a Public Utility Commission --

MS. HORVATH: Right.

DEMOCRATIC CHAIRMAN FRANKEL: -- and setting prices. So, as I understand it -- and I'd like you to maybe to go through this briefly. You know, instead of having all these different layers adding to the price where everybody gets a piece of the pie, the pharmaceutical affordability board basically sets the price, and then you work down from there as to where everybody is getting their slice. Maybe you can kind of detail that a little bit.

MS. HORVATH: Yes. And I will say I did develop the model and trying to think about like how to manage this and how to manage it fairly because I have great respect for the drug industry. I think it's terrible that people so despise the industry because of pricing and that people can't get their meds. I mean, that's not why these companies exist. That's not why scientists work for these companies.

So, a drug affordability board, you know, I think in this day and age if it were to be created tomorrow would consult with health plans and State payers and everybody else and figure out what is their net. What is that gross-to-net bubble there? And in some cases it's 70 or 80 percent. And maybe that then becomes the upper payment limit in a State. That becomes what consumers pay. That becomes what every transaction around the State is, is built on what the consumer pays.

And manufacturers aren't necessarily taking a hit at that point if they're already giving at the office 70 percent off in terms of rebates to somebody in the system. It's just taking that and making it the number and building the whole supply chain off of it.

And the most important thing in terms of making things affordable is to make sure that the pharmacy pays an affordable cost and that the pharmacy bills the insurer and the patient that affordable cost. Like nothing's going to change as long as everything is rebates and confidential and stuff. And, you know, pharma is right that, you know, they're giving a massive amount in terms of rebates. And if that money just sort of moved up front, it would benefit the patients. So much more would change as a result of that.

And I'm just saying you could do that off the

top. That may still not be an affordable drug, but there's just that much money in the system now to even just start to work with.

DEMOCRATIC CHAIRMAN FRANKEL: Thank you. And one other quick item, maybe not quick, but can you tell us what percentage of a drug's cost is research and development or manufacturing and how much of drug costs are manufacturers spending on advertising and administration and how much is profit roughly since you've been in the industry?

MS. HORVATH: No, I can't. Those are confidential numbers, and the company I work for knew better than to tell me those things. I mean, if that's not your business in the company, you know, you don't necessarily know, and those are numbers that the industry finds to be trade secrets.

And I guess my feeling is at the point in time in which it becomes important for the industry to tell you that for purposes of policymaking, they will. And if it's really not germane, they won't. But if it's not germane to them, it shouldn't be germane to policymakers. That's the view I've come to.

DEMOCRATIC CHAIRMAN FRANKEL: Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Chairman Frankel. Representative DeLissio has a question.

REPRESENTATIVE DELISSIO: Yes, thank you,

Chairwoman.

When you had commented, Ms. Horvath, that rebates go to insurers for premium stabilization, I might be more inclined to embrace that if so many of the executives and insurance companies weren't making seven-figure salaries. So, I'd be curious to see -- because we see this even in the utility companies as to how this -- and I think absolutely something needs to be done, but how this regulatory process even currently as it pertains to utilities, you know, the rates still go up, I still have constituents who pay more for the very basics, which are heat, electric, water. And for many of them there are still budget strains --

MS. HORVATH: Right.

REPRESENTATIVE DELISSIO: -- so I would hope in this case that if we were to head down that road, we would put the appropriate boundaries and restraints in place that doesn't stifle research and development, absolutely important, but what the first speaker was saying and talked about, new drugs were slightly modified versions of an older drug to really keep that market going.

MS. HORVATH: Right.

REPRESENTATIVE DELISSIO: We're incentivizing I think here the whole wrong thing.

MS. HORVATH: Yes.

REPRESENTATIVE DELISSIO: This is an enriching folks at the expense of others. When I have somebody saying they have a $700 copay, that's beyond nuts, and I have to make three phone calls including to the pharmaceutical company in order to get that changed. Nobody should have to go through that.

So, as much as I like the concept of some type of a statewide board looking at this, I would just caution my colleagues that we're going to have to be really, really thoughtful because our everyday citizens are not influencing the process as many other special interest groups are. Thank you.

MS. HORVATH: I would be the first to say that this idea, it's not perfect. It's not perfect. But I would also anticipate that, as part of this process, you know, health plans need to make some agreements, too, you know, in terms of how they structure it, make some agreements, too, to be part of the process that, you know, once a drug is acted on by the board, yes, you know, it has to be affordable to the patients and then to the health system. And right now, patients are in between everybody. You know, everybody uses the patient to try to leverage their ability to either maintain price or lower price.

MAJORITY CHAIRWOMAN RAPP: Thank you. Representative Daley?

REPRESENTATIVE DALEY: Thanks, Madam Chair.

I was reading to get ready for this meeting, and there was a part of me that was, you know, replacing this whole drug industry and the patient, and it occurred to me that you should handle it like Public Utility Commission in some way.

But I also come from a background of working at University of Pennsylvania for 20 years with people who did biomedical research, and so the research aspect of it is interesting and kind of -- well, let's say it's interesting to me because, you know, you see how long it takes for research and all the different phases research goes through, and I think that it's a valuable part of it. And I don't even -- like so many drug companies have shut down their research and development --

MS. HORVATH: They have.

REPRESENTATIVE DALEY: -- so it's really -- I agree with my colleague, Representative DeLissio, that it was really distressing. And we've heard this before, that there's just a reformulation, slight change to a drug so that the patent period can be extended and then, therefore, the exclusivity. So, you know, is that research part of it also something that we need to be looking at? Because --

MS. HORVATH: So --

REPRESENTATIVE DALEY: -- it's important, and

there are so many things that we're not even addressing in terms of developing treatments for them. I don't know where the money comes from for that. I mean, I don't even know how much the Federal Government puts into it, but that's an area that I think also needs to be explored.

MS. HORVATH: So, there's a Federal bill called the We PAID Act, and it also establishes a national prescription drug affordability board basically, but it also looks at that piece. So when a university goes to patent a molecule, in order to get that patent, they've got to report where they got the money from. And if it was a bunch of NIH money -- because everybody feels like we've already paid for the drug in terms of the development and stuff, so as taxpayers and patients, we keep paying and paying and paying. So, I mean, that would be interesting to have disclosure, not that it would crimp academic ability to get NIH funds and use them in research in any way. It just is transparency.

And then in terms of the me-too product to sort of extend a patent life, you know what, I think a board could look at that, you know, and decide that, you know, what makes that affordable? Or maybe the board doesn't even need to look at that. Do you know what I mean? Like it's not creating a financial challenge. All of this depends on the drug I think, you know, how many competitor

products that do similar things there are in the marketplace so there's not going to be one rule of thumb that it would happen exactly this way. It just depends on the products.

REPRESENTATIVE DALEY: That's really interesting. I don't think the Federal Government pays for all of the drugs or the research. I just --

MS. HORVATH: No, they don't.

REPRESENTATIVE DALEY: I think a fair look at how the research industry in the United States works is also something because it's not really as simple. It's expensive to do research.

MS. HORVATH: It is.

REPRESENTATIVE DALEY: It's a very competitive area, and you want to keep attracting people to be able to do that kind of work because otherwise, how are we going to make discoveries --

MS. HORVATH: Yes.

REPRESENTATIVE DALEY: -- so I do appreciate what you're saying. For me, it's raised a lot more questions, which is always a good thing --

MS. HORVATH: Yes.

REPRESENTATIVE DALEY: -- in public policy.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative. Representative Schlossberg.

REPRESENTATIVE SCHLOSSBERG: Thank you. Thank you. And thank you, Ms. Horvath. This has been genuinely interesting.

I really appreciate the brief that you laid out for us because I think it does an excellent job of laying out options but also limitations. And it's those limitations that I have some questions on. It seems like everything -- not everything but many of the things that you suggested are limited by case law or FDA law or Medicaid law. Every one of us gets questions about prescription drug prices, and typically, my response -- I suspect the response of many of my colleagues -- is at the State there's not a ton we can do. Within the scope of what you laid out here, what are some options that don't run afoul of any of the pretty significant constraints that we have on us?

MS. HORVATH: So, interestingly, importation from Canada seems to be immune from suit, pharmaceutical companies suing the State. And that's what I look at like, you know, who's going to sue? I think PBM disclosure when it's written through the State commercial insurance code as opposed to creating a new section of law for PBMs --

REPRESENTATIVE SCHLOSSBERG: We did that if I'm not -- well --

MS. HORVATH: You may have. I apologize.

REPRESENTATIVE SCHLOSSBERG: No, no, no --

MS. HORVATH: But that is an area I think it's going to be hard to sue. And, as we heard, I think some rules around fair business practices in the PBM industry are warranted. And then, again, I apologize. I feel like I'm pitching this thing, and I don't really mean to be doing that, but the board idea is designed -- I mean, it's a little complicated, but it is designed to sustain, be sustained in a dormant commerce clause constitutional challenge. That's why it's based on costs --

REPRESENTATIVE SCHLOSSBERG: Right.

MS. HORVATH: -- and that upper payment or cost limit is applied to State-licensed and regulated entities.

REPRESENTATIVE SCHLOSSBERG: Okay.

MS. HORVATH: So, it leaves the manufacturer free to price however they want, wherever they want as opposed to -- so that gets at some of the case law.

REPRESENTATIVE SCHLOSSBERG: Right.

MS. HORVATH: And then, you know, that board, like importation, it applies to stuff that is -- pharmaceuticals in the State intended for patients and individuals in the State. That's another key component. Those are like the pieces. It's got to be in the State, right? It can't be exerting burdensome influence on the behavior of manufacturers outside of the State. It can't

violate patent law, so those are really the parameters.

REPRESENTATIVE SCHLOSSBERG: So, I have no doubt an accurate answer and a frustrating one because what we can do remains pretty limited it sounds like.

MS. HORVATH: It does, and I don't mean to be Debbie Downer, but I do think there are some things --

REPRESENTATIVE SCHLOSSBERG: Yes.

MS. HORVATH: -- that can be done, and I think the most important thing is setting precedents and having Congress -- because really, you know, the best solution is a national one in this particular arena -- setting precedent and giving them sort of some ideas on where to go. There are two bills now in Congress both on the Senate side on creating a drug affordability board.

REPRESENTATIVE SCHLOSSBERG: Thank you very much.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative.

I have just a brief question. Where we are seeing a few States in the Nation looking at insulin cap legislation.

MS. HORVATH: Yes.

MAJORITY CHAIRWOMAN RAPP: Are you familiar with that and --

MS. HORVATH: I am.

MAJORITY CHAIRWOMAN RAPP: And what's your

opinion? And is this something that you believe would be beneficial to people with diabetes?

MS. HORVATH: Oh, yes. Yes, absolutely. People are literally dying because they can't afford their insulin, you know, and that's just a horrible situation. So, you know, I think that this is solving for a specific problem. Colorado was the first State, and there's a whole bunch of States now that are requiring their insurers to cap the cost of out-of-pocket cost of insulin. Some States are going further and capping the out-of-pocket cost of all drugs covered by all commercial plans in the State. At a certain point you start to affect the health plan's ability to manage their costs and keep control of their premiums.

I don't know -- the industry here should speak to whether a cap based on the health profile of Pennsylvanians, you know, if that is going to be a real problem or not. It wasn't a problem in terms of premiums and all that in Colorado.

MAJORITY CHAIRWOMAN RAPP: Thank you very much for being here today. We really --

MS. HORVATH: My pleasure.

MAJORITY CHAIRWOMAN RAPP: -- appreciate you taking the time out of your busy schedule. Safe travels. Thank you very much, Ms. Horvath.

Our next person to present to us today is Sarah

Emond, who is the Chief Operating Officer for the Institute for Clinical and Economic Review. You're the Executive Vice President. So, please begin whenever you're ready.

MS. EMOND: Well, thank you, Madam Chairwoman, Mr. Chairman, and all of the Honorable Members of the Health Committee, an honor to be with you today. As the Chairwoman noted, I'm from a group called the Institute for Clinical and Economic Review, and that's a mouthful so we can use ICER today as we're talking. And, importantly, I do want to note we do not lobby for any particular pieces of legislation, but we do welcome the opportunity to speak with policymakers about the issues around drug pricing in particular because of where we sit, what we've learned from our research and some of the ideas we have for solutions.

We heard a lot today. Antonio did a great job. Jane's done a great job talking about the problem. I'll mention that when we've talked to many manufacturers about how they set their price, we get a lot of different answers. It can be the value that patients receive. It could be the value to society. Some say it's what the market will bear. Others will say it's because of the size of the population that might be treated with the drug. Some say it depends on what our competitors charge. And some even say they have a moral requirement to charge as much as possible.

What you hear through all these reasons is inconsistency. There is not one way that a manufacturer chooses its price. They have admitted this, and there's a ton of research that sort of supports the fact that there's no one way. And what that leads to is a situation where those of us who want patients to be able to get access to the drugs that they need, we have no way of judging their choice of price as fair or not fair.

And I will reiterate something Antonio mentioned to us earlier. The government is granting a monopoly in this case and allows them the ability to set the price. And so it leads to the question of how do we judge whether or not that price is fair? I don't need to tell Members of this Committee because I've already heard and I could have guessed that you're hearing daily from your constituents about how difficult it is to afford their prescription drugs. Kaiser Family Foundation did a survey back in November that showed 79 percent of respondents said the price of drugs was unreasonable.

Drug makers also have no regulatory or statutory restraint on raising prices. Some companies raise prices multiple times a year often at rates much above that of inflation simply, seemingly, because they can. In our first annual unsupported price increase report, we actually found that net price increases on just seven drugs in 2017

and 2018 resulted in an excess of $4.8 billion of spend by Americans.

One quick detour into rebates because you're going to hear a lot about rebates. We already have, the gross-to-net bubble, all of these things are very important. I do want to emphasize that this issue is extremely important in a select number of classes of drugs, when there are multiple competitors, when there is the ability for the pharmacy benefit manager to use market forces to extract larger and larger discounts in exchange for formulary placement. And there's times when it harms patients. The idea that patients should be asked to pay a coinsurance on list price when no one is paying list price is frankly bananas, and that's a technical term.

And we have little transparency about how the rebate savings are being shared with the payers, with the employers, and with the patients themselves. I'm happy to report that because of the attention that this has received, more and more payers are offering what they call point-of-sale rebates where the patient is paying their coinsurance on net price. This is a step in the right direction but, again, still a symptom of the larger problem.

What you have here are both sides pointing fingers, but we believe it is possible to have fair prices,

have fair access for patients, and plenty of money for future innovation. We consider this the grand bargain. We think there is a way to incentivize manufacturers through their research and development through the data that they produce to demonstrate the value of their product, and we can reward them with high prices. And what that means is when there's me-too innovation or a drug that only offers a marginal benefit to patients, we don't see quite as high prices.

So, how do we do this? Simply, we take the evidence on the clinical benefit -- this evidence comes from the manufacturers themselves as part of the clinical trials for the product -- we calculate a fair price using a systematic review of the drug's comparative clinical effectiveness versus what we already do, combined with an analysis of the drug's long-term cost effectiveness versus the other options.

Our methods are transparent. It is an eight-month process. It involves several points for public comment and interaction with patients and their families at the center of the process from day one. Our work aims to signal what a fair price is, not to signal whether or not a patient should be able to get access to that drug.

So, a quick primer on cost-effectiveness in 90 seconds. Cost-effectiveness measures all of the health

gains and the side effects offered by two or more different treatments compared to all of the new costs and the cost savings offered by the therapies. Simply put, cost-effectiveness measures the improvements in length of life and quality of life as judged by the patients taking the medicine often through a measure called the quality adjusted life year, and then we scale the price to the benefits demonstrated by the drug using a consistent and well-established approach linked to the overall wealth of a society.

When we conduct cost-effectiveness, we're able to judge the fairness of an estimated net price, which can help signal to policymakers where more attention might be needed. It is possible to have a health system where the prices of drugs are aligned with their health benefit, and we see promising examples of just that.

One example was a drug called dupilumab, a new therapy for severe eczema manufactured by Regeneron in Santa Fe. During our review, we were working with the manufacturer because we wanted to be sure we had all of the data available in order to show the full value of this drug and what it meant to patients. And they did just that. They give us access to data that hadn't been published previously. They worked with us to help us understand what the data were showing, the data directly from the patients

in their clinical trial, and they made a public commitment to pricing their drug in ICER's fair price range, and in turn then put pressure on payers to make sure that patients got access and that they didn't have to go through onerous utilization management and step therapy. And that's exactly what happened.

We have a few other examples that I can get into in the Q&A, but we think that this is the future of how drug pricing can work for patients.

I want to note that the work we do is not without controversy. There are many people who have invested in the status quo staying exactly the way it is. And, unfortunately, they have used misinformation and fear to scare patients into thinking that doing cost-effectiveness and measuring improvements in quality of life and length of life somehow discriminates against people with disabilities or those who are older.

Measuring the benefits of patients using cost-effectiveness is never used to say that patients that start out healthier should get medicine before patients that are older, sicker, or have disabilities. That would be unethical. The quality adjusted life year is a measure that helps society know the fair price for all patients that took the drug regardless of age, other conditions, or any disabilities those patients have. It would be

unethical to try and decide a fair price for the drugs for just people without disabilities or just for young people.

We're willing to stand by our work by working with States, Federal policymakers, and others to enact safeguard language that would prevent our work from ever being used to discriminate. This language could say, when using cost-effectiveness, policymakers cannot use information that uses the cost per quality adjusted life year or similar measure to identify subpopulations for which treatment would be less cost-effective due to severity of illness, age, or pre-existing disability.

All right. Let's talk about what States can do. Jane did a wonderful job outlining some of the limitations to what States can do but the opportunities that States have to use information to try to get fairer drug prices. I want to tell you what New York did in their Medicaid department. They passed a law in 2017 that put their prescription drug spending for Medicaid on a cap. They used actuarial analyses to say this is how much more we are allowed to spend on prescription drugs year-over-year, and when we are projected to pierce that cap, we are allowed to go look at the drugs, the spending on which is contributing to us overspending on prescription drugs. The legislation gave them a number of tools to extract additional rebates from the manufacturers for the drugs that they've

identified.

In the first year alone they identified 30 drugs from 12 manufacturers, and they didn't say this publicly, but you can figure it out from math that they got additional rebates on 29 drugs from 11 manufacturers. How we know that math is there was one manufacturer that refused to give a supplemental rebate. That manufacturer is Vertex, and the drug is Orkambi for cystic fibrosis.

So, because they refused to give an additional rebate, the law allowed that company to be referred to a public process where the drug utilization review board then looked at information about the utilization of the drug, the price of the drug, how much spending the State has made for the drug. And the drug utilization review board took that information and then said this is a supplemental rebate amount we should get for this drug. An important component of their deliberation was our independent analysis of what a fair price was for Orkambi, which represented a 75 percent discount off of the list price of the drug.

ICER's work also informs a pay-up-to approach. We're very happy about the interest we're receiving from policymakers in this approach because this results in broad access for patients. If the ICER price is the ceiling price, you as a payer -- well, Medicaid's a little bit

different, but as a payer or some like the VA could say I will pay up to this amount and ensure that all of my members, all of my patients get access, and then we can talk about what we do with the difference. Do you give it to me as a rebate? Is it an up-front discount? Do you use your patient assistance program to help patients afford the difference?

There's important nuances that we need to unpack in terms of what you do with that difference, but the idea is getting a lot of traction. It also could play into a prescription drug affordability board. If the prescription drug affordability board is looking for an independent analysis of what the ceiling price should be, something like an ICER report that has a price that shows you the exact price that matches the clinical benefit that a patient receives could be very helpful.

The other thing I'll mention is price increases. I mentioned our unsupported price increase report. ICER comes at this by thinking that there are times when a price increase is warranted, and there are people who might disagree with that. But we believe that it would be warranted if the manufacturer approved additional clinical benefit or improved safety. That's exactly what we want to see in postmarketing trials and real-world evidence. If that happened, ICER's research would then show we should be

paying a higher price.

And our unsupported price increase report identifies drugs that have not demonstrated any additional evidence of value for patients, and so, again, could signal to policymakers here are the drugs that we need to pay attention to in terms of what we need to be thinking about in terms of intervention.

I want to just remind everybody -- I don't really need to remind anyone here, I realize that, but, at the end of the day, why are we having this conversation? Why was this room packed this morning? It's because of patients like Ray. Ray saw a drug approved for his rare disease. It was available for $450,000 a year. Even with insurance, he was facing an unmanageable expense, and Ray knew that his small employer would be facing difficult trade-offs around wages, expansion, and premium increases if he were to take the drug. So, he was deciding whether to take the drug or enter palliative care to preserve some financial resources for his family after he was gone. This is not a decision any of us would ever want to have to make and yet families face in this country every day. We can do better. We can have amazing innovation that improves the lives of patients like Ray without bankrupting families, employers, and States.

Again, my thanks for the invitation to be here

today. I'd be happy to take any questions.

MAJORITY CHAIRWOMAN RAPP: Sarah, if you wouldn't mind, we're going to wait until the next presenter, and then you can come back up and --

MS. EMOND: Beautiful.

MAJORITY CHAIRWOMAN RAPP: -- we'll ask questions and try to link back up with Antonio as well.

So, just for the Members' information, our last presenter that's on the agenda, Christopher Molineaux, actually came down with a bad case of the flu, so he will not be presenting today.

So, our next presenter is Lauren Neves, who is the Senior Director of Policy and Research, Pharmaceutical Research and Manufacturers of America. Lauren, welcome, and you may begin whenever you are ready.

MS. NEVES: Thank you so much, Chairwoman Rapp, and Members of the Committee. My name, as she just said, is Lauren Neves, and I'm here on behalf of the Pharmaceutical Researchers and Manufacturers of America. I am thrilled to be back in my home State of Pennsylvania, just 30 minutes from where I grew up in Manchester Township in York County, talking about drug prices -- closer? Okay. -- and how we can work together to make sure patients can actually afford their medicines. I think that's something everyone who's spoken here today can agree on.

So, my organization, Pharma, represents the country's leading biopharmaceutical companies, and we're devoted to developing treatments that will help patients live longer and better lives. In this decade our member companies have actually invested more than $900 billion in research for new treatments and cures.

And I want to go back to something Jane spoke to earlier. She talked about how we don't talk about what we spend on R&D and what we spend on marketing. That's not true. We are happy to talk about that. In 2016 we spent $90 billion on R&D, and we spent a third of that on marketing, so I just wanted to go back and correct the record there.

America leads the world in medical innovation driven by a market-based health care system and policies that actually promote investment in new discoveries. And that translates into hope for Pennsylvanians, people like my family.

So, I'm going to give you three recent examples. First, because of innovative medicines, hepatitis C is actually curable in 90 percent of cases these days. We also just saw the single biggest drop in a single year of cancer deaths according to report that just came out from the American Cancer Society only a couple weeks ago. And they attributed that in large part to new medicines. More

than half the people in Pennsylvania have high cholesterol, but new medicines are actually changing the way we treat it, and there's been a 36 percent drop in deaths in the last decade.

But those are just the medicines we have today. There are 8,000 medicines in the pipeline right now, and that process is risky, and it's complicated. It takes on an average a decade and an estimated $2.6 billion to bring a drug to market. And unlike a lot of products we see today, those drugs are being developed in America by Americans, including Pennsylvanians where our industry is a really important part of the State's economy.

More than a quarter million of Pennsylvanians are employed in jobs that are supported by our industry, and those are good-paying jobs. Those individuals are paid nearly twice the salary of the average worker in this State. Those treatments, they won't help people who can't afford them, and we know that.

We know that for far too many Pennsylvanians the health care system as it is right now is just not working for a lot of the reasons that Antonio and Jane and others have talked about. There aren't any easy solutions, but patients here need leadership from all stakeholders to figure out how to make it work better.

And we believe affordability for patients is

paramount. But it is a myth that the price of prescription medicines are skyrocketing. I'm going to go back to something Antonio said a little while ago. Net prices for medicines grew .3 percent in 2018, .3 percent. That's roughly in line with inflation. Now, compared to other segments of the health care system, growth in drug spending is actually pretty small. Over the last 10 years, both hospital care and physician care grew more than drug spending. In fact, prescription medicines contribute only 14 percent to overall health care spending. That's a pretty small slice of the pie.

And, to make matters worse, our pharmaceutical supply chain, as a lot of people have already talked about today, has only grown more complicated over time. We've already talked a lot about PBMs, whose job it is to negotiate really steep discounts and rebates off of prescription medicines. Their job is to work on behalf of insurance companies. They are not working to make drugs cheaper for patients.

So, as Antonio said, nearly half of all spending on brand medicines is going to stakeholders and not the companies who research, develop, and manufacture the drugs. Let me say that again. Nearly half of all spending on drugs is not going to drug companies. Rebates and discounts, as Antonio mentioned, have doubled to $166

billion. And it's not just the PBMs. They're not the only ones at fault here. The amount health care providers, including hospitals and pharmacies, are retaining actually doubled between 2013 and 2018.

And it's not a blip; it's a trend. If you look at slide 8 of my presentation, you'll see a chart. What this chart tells you is that PBMs and entities like PBMs have received a larger and larger share of total spending over the last eight or so years. The author of this study, which actually just came out last month, believes that over the next couple years those trendlines are actually going to cross meaning that manufacturers are actually going to wind up keeping less than other entities in terms of spending on drugs. We're going to keep less.

Now, for certain medicines like asthma, high cholesterol, diabetes medicines, rebates can take up to 70 percent off the list price of a drug, so as payers and PBMs use their not-insignificant leverage to demand lower prices for drugs, patients keep paying more at the pharmacy counter. And I think that's something everyone who's talked here today can agree on. Everyone in this scenario is winning except for the patient. For more than half of commercially insured patients, their out-of-pocket spending for brand medicines is actually based on the full list price of the drug meaning they're not seeing the benefit of

those discounts and rebates.

And, as you can see on slide 10 for those of you who have the slides, in some instances a patient could actually wind up paying more than their insurance company for a medicine. In this example, the list price of the patient's drug is $400, and they pay a 25 percent coinsurance, which isn't all that uncommon these days, meaning that they're going to pay $100 at the pharmacy counter. But their payer negotiated a 65 percent rebate off the price of the drug, meaning they pay $140. And the patient is giving them $100 back. That means that the patient is paying $100 for a drug that their insurance company is only paying $40 for. The health care system isn't working for this patient, and it's not working for a lot of Pennsylvanians.

Now, a lot of payers have claimed that sharing discounts with patients would actually cause premiums to skyrocket, so they'd just wind up paying for it somewhere else, but that's not true. On slide 11 you can see that sharing savings with patients would actually increase premiums by 1 percent at most.

And research has shown that passing through rebates and discounts could improve affordability. So, take diabetes patients for example. Sharing 100 percent of rebates with diabetes patients would decrease their out-of-

pocket costs by 40 percent or $791 per patient per year. That's a lot of money. It would also reduce other avoidable costs, things like ER visit, hospitalizations, which our system spends so much money on, to the tune of about $435 million a year.

And this kind of relief is desperately needed. More than half of health plans now have deductibles, and those have increased 360 percent since 2006. That means patients are having to pay more for longer at the beginning of their plan year before their insurance company starts helping them out with their out-of-pocket costs.

And it's not just deductibles. Over the last decade, the number of plans that have four or more tiers of cost-sharing has actually increased to 44 percent. And when you have more tiers of cost-sharing, that usually means higher costs because higher tiers mean more patients are paying coinsurance, and a coinsurance is a percent off the list price of the product meaning you're not benefiting from those rebates and discounts.

And that brings me to the reason we're all here today, right? How do we fix this? The wrong way is through policies that would let a government or an organization like ICER set prices for medicines like the United Kingdom and Germany and places in Europe do. That type of policy threatens access, and it threatens

innovation. We have clear evidence of this. We don't need to experiment. In foreign countries where the government sets prices for medicines where they use affordability boards, places like the U.K., Germany, and France, they have access to far fewer innovative medicines than we have here.

There's also clear evidence that this type of policy has a negative impact on innovation. So, in 1986 the U.S. actually trailed Europe in biopharma R&D investment by about 24 percent. Today, Europe trails us by 40 percent. We can't afford to lose that innovation. We can't afford to lose the research that could lead to the next cure for Alzheimer's or ALS or cancer. We need solutions that are going to help patients afford their medicines and not increase barriers to access and not take away their hope.

So, here are solutions:

First, we must require that insurers and PBMs pass those rebates and discounts that they receive from us along to patients.

Second, in some cases, insurers aren't allowing the coupons that manufacturers provide to patients to count towards their deductibles. So, we provide millions and millions of dollars in assistance to patients every year in the form of coupons, free drugs, but insurers aren't

letting them count them towards deductibles, which means patients are paying thousands more at the pharmacy counter than they really should be.

Third, patients need to have more choices when it comes to medicine coverage. Health insurers need to offer at least a couple of plan options where medicines are actually excluded from the deductible and where their cost-sharing is just based on set copays, not coinsurance based off of a list price of a drug.

Additionally, it's really important to Pharma that our industry does our part. Pharma member companies have created the medication assistance tool or what we call MAT. It's a website, and it gives patients, your constituents, caregivers, physicians information on where they can find financial assistance from our companies. It also links to member company websites where you can find out about the cost of prescription medicines. So, we talked a little bit about transparency earlier. That information is on our member website. If you go to MAT, you can find links to those places, and you can learn about the cost of drugs. We think transparency is important.

So, in closing, innovation really depends on having a U.S. market that's three things: free, competitive, and predictable. These solutions have the potential to vastly improve that market. We want to make

the market work better and help patients afford their drugs and thrive without financial hardship. And we look forward to working with the Committee and all the other speakers today to create such change. Thank you again for having me.

MAJORITY CHAIRWOMAN RAPP: Thank you very much, Lauren. If you would just like to keep your seat there, and I'll invite Sarah back. And if we can get Antonio back on the screen.

MR. CIACCIA: All right. Are we back?

MAJORITY CHAIRWOMAN RAPP: We are back.

MR. CIACCIA: All right. Well, let me first apologize. I think I broke my promise to Whitney --

MAJORITY CHAIRWOMAN RAPP: Okay. Hold on just --

MR. CIACCIA: -- that I would be a little bit quicker.

MAJORITY CHAIRWOMAN RAPP: Hold on just a second.

MR. CIACCIA: I'll get --

MAJORITY CHAIRWOMAN RAPP: Can you hold on just a second?

MR. CIACCIA: Absolutely.

MAJORITY CHAIRWOMAN RAPP: Okay. For the Members and the public, I did want to inform you that we did request representation from insurance, but they were not able to provide us with a presenter today, so that door is

always open just for your information. We certainly can always conduct another hearing, and they are always welcome to the table.

So, at this point in time I am going to open the remaining time. And it's currently 11:10. I think we had planned for about 11:30. If we want to go a little bit longer, that will be determined by our presenters, so if you want to endure a little bit longer, that's -- or we can conclude at 11:30.

So, Chairman Frankel, did you have a question?

DEMOCRATIC CHAIRMAN FRANKEL: Thank you. I mean, I really appreciate the Chair putting this hearing together, and I think it's obviously an extremely important thing that we do get talked to by our constituents constantly.

I guess I missed the beginning. Ms. Neves?

MS. NEVES: Neves.

DEMOCRATIC CHAIRMAN FRANKEL: Neves? Thanks.

MS. NEVES: It's hard to pronounce.

DEMOCRATIC CHAIRMAN FRANKEL: The issue of, you know, the comparison between us and countries where there are --

MS. NEVES: Sure.

DEMOCRATIC CHAIRMAN FRANKEL: -- price controls, I mean, it has always occurred to me -- and I think our

first presenter spoke to this. When you take a look at health care costs in the United States compared with the developed economies around the country, whether they're in Europe, Canada, or Asia --

MS. NEVES: Yes.

DEMOCRATIC CHAIRMAN FRANKEL: -- they are spending half of what we do on health care, and they have those controls that you talked about. And their results, contrary to what I think you were implying in terms of life expectancy, infant mortality, and chronic illness, you know, put us to shame in terms of health care outcomes. So, we're paying twice as much. Pharmaceutical costs are increasingly becoming more and more of that part of the equation. So, that's a concern. And I think also our first presenter talked about the fact that to a certain extent what the pricing mechanisms are here in the United States, part of that is basically being used to subsidize lower pricing in these other countries where there are some price controls. So, you know, there are so many issues here at the end of the day that are of concern.

And I also wanted to ask you, you know, we heard that pharmaceutical companies can already provide point-of-sale rebates. Is there anything stopping them from doing that to help consumers right away without us coming in to do that? So, maybe --

MS. NEVES: I can take all of it.

DEMOCRATIC CHAIRMAN FRANKEL: And both of you can weigh in.

MS. NEVES: I would welcome Antonio and Sarah to also jump in.

MAJORITY CHAIRWOMAN RAPP: Antonio is on the screen --

DEMOCRATIC CHAIRMAN FRANKEL: And Antonio, right.

MS. NEVES: Yes, he's right there. So, I saw the chart Antonio presented about health expenditures and health outcomes, and I think that's a really good question you're asking. So, drugs can't solve all health care problems. There's a lot of lifestyles and societal factors that go into those health outcomes. You mentioned infant mortality, you know, you mentioned life expectancy. There a lot of things that go into it.

In the disease areas where drugs actually do make a difference, life expectancy is better here. So, what Antonio showed you was for everything overall. It's for general health outcomes measure. So, for example, cancer, let's take that as an example. Life expectancy for people with brain cancer, for children with brain cancer in the U.S. is 40 percent higher than it is in the United Kingdom, and that's because we have good drugs to treat it. So, on things like cancer, chronic conditions, things where drugs

are actually helpful, we actually have better health outcomes. So, that's the piece of the narrative that I think is missing. So, I just wanted to respond to that directly.

In terms of point-of-sale rebates, so we can't offer point-of-sale rebates directly. That's for the pharmacy benefit managers and the pharmacies to do. So, those prices would have to be passed on by them. So, the ball is in their court. As you said, they're not here to defend themselves, but that's what I would say.

MAJORITY CHAIRWOMAN RAPP: [inaudible] the microphone?

MS. NEVES: I'm sorry. I just don't want to get too close to it. The flu is going around.

MS. EMOND: I can chime in on that a little bit if that's all right. I had the pleasure of knowing Uwe Reinhardt, who was a beloved health economist from Princeton who passed away last year. And he is famous for saying it's the price of stupid. Prices are a conscious choice that impacts access. And so we have a situation where there is no bound on what manufacturers can charge.

And Lauren is right that there's some evidence and some research that shows we might have less innovation if we had some downward pressure on prices, but the most recent analysis of that was actually done for H.R. 3,

Pelosi's drug pricing bill, which predicted line 8 to 17, fewer drugs over 10 years I think was the analysis. Am I close? And what commentators have chimed in and said it's very likely those fewer drugs would be those me-too drugs that offer very little improvement for patients, and it's not going to be things like the $2.1 million gene therapy that cures children of SMA, which ICER judged was a fair price.

So, it's not about whether or not we are going to have the same number of drugs approved and developed. It's are they the ones that are actually benefiting patients?

MAJORITY CHAIRWOMAN RAPP: Thank you. Antonio, did you want to weigh in on that question?

MR. CIACCIA: Yes, thank you very much. What I would say is that it's really hard to predict what policy is going to do to innovation in the future. So, I would take any of those -- while it's important to consider those things, I typically take them with a grain of salt because it's very hard to determine how the market is going to respond.

Moving to a system where you move the rebates to the point of sale I would argue is probably better than the current model that we have today, but I would caution you back to one of the slides I pointed out before is rebates don't create a system of winners and losers. And so if

you're pushing those prices through, congratulations, you've pushed them back to the patient. You've essentially sterilized what little arbitrage there could be going on on branding rebates, but you still have the system where your small commercial payers and your patients that pay out-of-pocket, essentially, have very limited resources and leverage to push back into actually yield a higher rebate relative to what a government payer would or what a large employer could, so you still have a system of winners and losers, and you still have a sleight-of-hand on who gets the benefit, how the net price is set from payer to payer to payer.

MAJORITY CHAIRWOMAN RAPP: Thank you. I believe our next question comes from Representative DeLissio.

REPRESENTATIVE DELISSIO: Thank you, Madam Chairwoman.

Lauren, I believe you said about $90 billion with a B is spent on research and development?

MS. NEVES: That's right.

REPRESENTATIVE DELISSIO: And that's annually and about $30 billion with a B is on marketing?

MS. NEVES: Yes.

REPRESENTATIVE DELISSIO: Is that marketing to the consumer or is that marketing to the licensed health care provider, who is the only individual who can give

access to what's being marketed?

MS. NEVES: That's a good question. It's all of it, so we use a relatively, you know, generous term for marketing or definition for marketing because we don't want to underestimate it, so it includes both direct and consumer advertising. It includes marketing to physicians. It includes marketing to everybody.

REPRESENTATIVE DELISSIO: Just as a follow-up, can you please tell me the point of marketing to consumers? They are not licensed health care providers. They have no way of really evaluating that. Some of them may have some background in it, but the majority of consumers are indeed just patients. Their information and their world is limited in terms of health care, so they are simply going to go to their health care provider to parrot a commercial that they saw on TV or an ad they saw on social media to bring that to the -- and I'm doing this because money in the system, like these costs are a lot, so --

MS. NEVES: Well, thank you for the question. I think it's a good one. You know, I think when you see directed consumer advertising as empowering patients. You know, not a lot of patients have access to information about the drugs that are available to them, and sometimes they need to be their own champions. You know, my father has wet AMD, age-related macular degeneration. And he went

to see an ophthalmologist, and that ophthalmologist told him he'd likely be blind in a couple of years. But then he did his own research on drugs, including look at, you know, websites for companies that I directed him to, and he found a treatment that actually works for him. And his, you know, degeneration of his vision has been halted.

So, I understand why you're asking that, but I think in some ways that information can really empower consumers to go talk to their physicians and ask them about their options. You know, physicians are the gatekeepers to medicine, but they don't always have all the answers. They don't always know what's best for their patients. Sometimes the patient really has to decide what's best for them.

REPRESENTATIVE DELISSIO: I'm all for consumers being their own advocates. And just a general comment, Madam Chair. This should not be this hard. We are talking about rebates and pricing and point-of-sale.

MS. NEVES: I agree.

REPRESENTATIVE DELISSIO: I mean, my heavens, this part right then and there, this should not be this hard. We should not be tweaking and manipulating a system that already today appears to be severely manipulated to get this particular commodity to folks who need it.

MS. NEVES: Absolutely.

REPRESENTATIVE DELISSIO: Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative. Representative Brad Roae.

REPRESENTATIVE ROAE: Thank you, Madam Chairwoman. My question -- you know, a couple of you might want to weigh in on this to answer the question, but the concerns I get most for my constituents, you know, involve insulin, you know, for diabetic treatment. Why is that one so much more expensive? And does insurance cover that the same way as other things, or is it just it's so expensive they have to pay more with deductibles and copays and stuff like that?

MS. NEVES: Do you want to take that?

MS. EMOND: I can. I mean, it is just like every other class where there's competition, so you can have very similar things that happen in rheumatoid arthritis, and psoriasis. What's happening is the PBMs are able to extract very large rebates in order for preferred formulary placement, and then they have an incentive to drive their members to those even when there are cheaper out-of-pocket options available. So, this is a perfect poster child for the dysfunction of the system.

What's interesting about insulin is that there could be the caps for some States have been thinking about, and that's addressing a symptom of the problem. It's not

addressing the problem itself. Remember that out-of-pocket costs, coinsurance, deductibles are the reaction from the employer community to try to maintain access to health insurance for its employees while still being able to do things like give wage increases. So, this type of cost shifting, while important and very worthy of policymaker attention, is a symptom of a broader problem. If you had a system with no rebates -- this is one we contemplated. It was put forth by the Trump Administration. We even have a white paper about this if anyone wants to nerd out about it. There are theories that premiums would increase because of those savings.

But I will go back to what Antonio said earlier. Right now, if premiums are lower because we're cost shifting to people with chronicle illnesses, that's the opposite of what health insurance is supposed to do because that means the sick is subsidizing the healthy.

MS. NEVES: I'll weigh in really quickly here since you asked about our drugs. So, we offer millions and millions of dollars in assistance to people to help them afford their insulins. And I would make an argument, like I did in my presentation, that those rebates and discounts we're giving to PBMs should be passed on to patients. It could save them a lot of money. It would save the system a lot of money.

I would also note that we are supportive of out-of-pocket caps on insulins like many States have done. So, pharma, you know, supports limiting patients' exposure in terms of copays to insulins.

MAJORITY CHAIRWOMAN RAPP: Yes. Antonio, did you want to weigh in on the insulin question?

MR. CIACCIA: Yes, absolutely. So, two things specifically. Both very correct, previous speakers. Any competitive class of drugs -- this is where, you know, my frustration with the system goes. In a traditional marketplace -- remove yourself from drugs, think of anything. In a marketplace with high competition, typically, you have providers' said product competing on price and service. And what that does is it typically increases the quality and it lowers the prices as each manufacturer of said product works to undercut the other in order to gain market share.

In a system that's predicated on rebates, you actually remove that traditional market function. Instead of manufacturers in the drug space competing on price to lower the price, they actually compete with one another to raise the price to make way for higher rebates to pass through back to the supply chain. So, competition works in the exact opposite effect in the drug industry. Heavy competition typically means that high gross-to-net bubble,

high list prices, very high rebates. Those who, again, get exposed to more of that price are impacted disproportionately.

The second thing is is the insulin marketplace is not lending itself substantially to generic competition, so there are generics that have hit the marketplace, but insurers and PBMs are chasing the rebate instead of bringing the generic version onto the formulary. So, you traditionally would see a generic drug hit the marketplace and totally upend the brand manufacturer that it seeks to copy. Insulin, we're seeing the exact opposite occur where generic comes to market and nobody's covering it.

REPRESENTATIVE ROAE: So, just real quickly, Chairman, so we might be better off -- I'm not saying we can't do both, but rather than passing a law like Colorado that says the patient only has to pay 100 bucks a month, we might be better off if we can do this, pass some kind of law that would make more generics available to bring down the cost.

MS. NEVES: And I would note that more generics are on the way. As was noted I think by Jane, you know, these drugs have a finite patent life, and a lot of these are going generic in the next couple years. So, you know, the money that we make now we put back into developing better, innovative drugs for, you know, diabetes for the

same things, and then at the end of that patent life, the system reaps the reward. So, I just wanted to note that as well.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative. I'm going to move to Representative Daley. I believe you have to leave, so please go ahead with your question.

REPRESENTATIVE DALEY: Thank you so much. One of the questions is -- I think I read it in our testifier who was not able to be here today, and I don't think anybody mentioned this, but the wholesalers that are in the middle of this, is this another group that we should be looking at their role in the path from drug company to drugmaker to patient?

MS. METZLER: You do have written testimony in your packet, and that is from the organization that represents the wholesalers.

REPRESENTATIVE DALEY: Okay.

MS. METZLER: So, we have asked. The date did not work for them, so they did provide written testimony. But we have them on standby if we have a second hearing.

REPRESENTATIVE DALEY: Okay. I happen to have a big one -- I just should say this probably. I happen to have a big one moving into my district with their worldwide headquarters, right down the street for my district office.

It's a big change that's happening. Can I ask another question?

MAJORITY CHAIRWOMAN RAPP: Yes, you may.

REPRESENTATIVE DALEY: Thank you. Thanks. This is a question related to the ICER. You said that you have this whole protocol for evaluating the fairness of the price of the drug.

MS. EMOND: Correct.

REPRESENTATIVE DALEY: So, I mean, how do you then deal with if the fair price of the drug is actually very expensive --

MS. EMOND: Right.

REPRESENTATIVE DALEY: -- what are the next steps?

MS. EMOND: So, we have no regulatory authority, so actually no one has to do what we say, which is what I often say to groups who are very worried that somehow there's going to be some sort of influx of ICER reports that say patients can't get access to their care because that's not ever what we do. What we do is further public conversation because, right now, payers make these decisions about coverage access, and manufacturers make decisions about price behind closed doors with no patients anywhere. They even have gag clauses in the agreements they sign with each other that say I can't tell you what

discount I'm giving you and you can't tell anyone what discount I'm giving you, and so there's all this secrecy around the status quo.

By moving the conversation out into an eight-month public process, we're trying to further a grown-up conversation about how we pay for health care with limited resources. And what I can tell you is absent and without regulatory authority, lots of people are using our work because they look to it as the independent assessment of whether or not they're getting ripped off.

There are times when we say our price is fair. There are times when we say the price could actually be higher and still be fair. But the majority of our work, about 85 to 90 percent of the time we show that the prices chosen by the manufacturer is higher than that of the clinical benefit that the patients are receiving.

REPRESENTATIVE DALEY: So, if you think about that there's no such thing as a free lunch, you're substantiating that. And it's one of the things that -- I don't know, I have a personal pet peeve when I hear all of these things are free because I feel like, well, somebody's paying for that. Senior citizens gets to pay nothing for public transportation, but that's only because the lottery is bringing in dollars to pay for it, so it's just one of those interesting conundrums I think that we have when you

think about low cost and it's free, that there's somewhere a cost. And so I think that's really interesting, the fact that you have this kind of a protocol and are looking at it in that way, so thank you.

MS. NEVES: So, can I make one comment in response to that? I just want to respond. When ICER says that the drug is cost-effective or high-value, that's not a guarantee of access. And I think Sarah would agree with me.

MS. EMOND: That's correct.

MS. NEVES: You know, they don't say very often that drugs are high-value, but one key example I would say is psoriasis treatments, which ICER found to be very high-value, I believe, and cost-effective due to a lot of patient engagement in that process and a lot of engagement from our member companies. Access actually got worse to those drugs after ICER's report came out. Utilization management restrictions, things like prior authorization, the things that keep you from just getting your drug got heavier and worse after ICER came out with their review, so I just wanted to point that out. It's not --

MS. EMOND: Because the price went up and they were no longer cost-effective.

MAJORITY CHAIRWOMAN RAPP: Thank you. And I think the point is very well taken that nothing is free.

We have a lot of taxpayers supporting a lot of what happens with our pharmaceuticals for people.

Antonio, did you want to weigh in on that question?

MR. CIACCIA: No, that's fine.

MAJORITY CHAIRWOMAN RAPP: Okay. Our next question comes from Representative Zimmerman.

REPRESENTATIVE ZIMMERMAN: Thank you, Madam Chair.

So, I'd be interested in hearing what the impacts of like a right to try that was passed has on this whole conversation from rebates to cost to drug manufacturing and the likes of that, so --

MS. NEVES: I can weigh in.

MS. EMOND: I'm very interested -- Lauren probably can teach me a little bit about this. What I have heard -- and so she's probably heard more directly, but from the manufacturers that we talk to, very few are actually participating in the right to try initiative. And I think in some ways that's a very positive sign from the pharmaceutical industry because they believe in the process of conducting clinical trials to prove that the drug works and is safe and effective, and they believe in the FDA process. And so the fact that you're not seeing a lot of manufacturers willingly give their drug over -- now, the

cynical side of me says it's also probably because of fear of litigation and all of those other things, but, I mean, that's a probably fair risk-averse behavior in this manner.

I would say that the social contract that we have developed is that society pays for a drug after a manufacturer proves it works, right? Like that's the social contract. That's why we have the FDA process. What I feel is -- what I have heard from many policymakers is they feel like the social contract has been broken in some regards. The FDA has lowered some of the evidence standards through accelerated approval in order to get very important drugs for very important conditions to patients faster, and in exchange has required lower bars for evidence generation. And the social contract would then say, well, perhaps you shouldn't charge $500,000 a year for this new drug because you're still developing the evidence to prove the clinical benefit for patients.

So, it's a bit related to your question about right to try. We do have a change in the level of evidence that we are seeing at approval because of some statutory things that the FDA is doing, and that should prompt us to think about what the fairness of the price is in that regard as well.

MS. NEVES: So, I'll comment on right to try. You know, right to try is tricky. I really understand the

desperation that a lot of people who want those drugs feel. I understand the desperation of having a sick child and just wanting to try anything to make them better. But the motto of our industry is do no harm. You know, we want to help people. And until drugs have been through that process that Sarah just spoke to, the FDA process, which, to be clear, is the gold standard for safety and efficacy throughout the world. We have the highest standards of anywhere in the world. It makes us very, very hesitant to give people access to a drug that we don't know meets that standard because we don't want to hurt those people. We don't want them to be in more pain than they currently are. So, it's certainly a difficult position to be in, and we certainly have sympathy for them.

I would say, just responding to Sarah's point about accelerated approval, that program was created because we want to get drugs to patients who don't have a lot of time left, sooner. We want them to go through the FDA process, but it's a lot of the same issue that you're talking about. Those people don't have time, people like lung cancer patients or patients with terminal diseases. We want them to not have to wait for the FDA's entire process to get access to those drugs. That's why those pathways exist. But those drugs still meet the evidence standards the FDA supports. And again, those evidence

standards are the highest in the world. So, I hope that answers your question.

MAJORITY CHAIRWOMAN RAPP: Antonio, did you want to weigh in on the right-to-try drugs?

MR. CIACCIA: Ohio passed right-to-try a couple years ago, and, you know, this is a personal comment. I think it's nice to have patients have that outlet. My grandfather, who lives in Moon Township, you know, he has amyloidosis, and there was a drug that doctors felt would be useful for him but that had not made it through the pipeline yet. And as somebody who is very selfishly in love with my grandfather, we were anxiously awaiting its approval. And I would like to think that we could have options available to us if they're not necessarily through the pipeline altogether, but that's more of a personal opinion.

MAJORITY CHAIRWOMAN RAPP: Thank you. Representative Keefer.

REPRESENTATIVE KEEFER: Thank you. So, getting back to the root of the problem and where we're at, so on average could you tell me how much -- like what percentage of the drugs are discounted or rebated? What percentage of all the drugs that you --

MS. NEVES: Yes, that's part of the answer. As Sarah said, it depends in part on who you ask, but it also

depends highly on what drug you're talking about. I'm hesitant to give you any kind of number specifically --

REPRESENTATIVE KEEFER: Is --

MS. NEVES: -- just because it's hard to pin that down.

REPRESENTATIVE KEEFER: Is there any drug that you don't discount, you know, when you have that third-party, any of them that you don't --

MS. NEVES: Sure.

REPRESENTATIVE KEEFER: -- discount or have a coupon for? I mean, it seems like, you know, I go to buy a car and it's listed at, you know, $60,000, but I know I'm not going to pay -- so, again, getting back to that, is there something that could be -- I'm not advocating for the State to come in and dictate what prices are, but I am saying you as the manufacturer looking at it saying, you know what -- you could almost independently cut out that third party by just saying, hey, this is how much this drug is, period without all that. You know, the cost-benefit analysis of doing that across the board would at least get rid of one level.

MS. NEVES: Yeah, and I think what Sarah is about to say is that there aren't rebates and discounts on all the drugs, and that's accurate. You know, there are certain drugs that we don't discount as heavily as others.

I mean, manufacturers make up for, you know, discounts in certain places by charging the full price sometimes for a drug for a certain period of time. And, again, I just want to reinforce that price only lasts until that drug goes generic or has a biosimilar competitor. So, even when they are, you know, asking for a full price of a drug, that's usually a time-limited option. And, again, we're supportive of passing rebates and discounts along to patients. That was my number one solution, and I believe that we should do that.

You also mentioned, you know, coupons and assistance for drugs that we don't necessarily offer discounts or rebates on. I would say there's two things. First of all, people have insurance for reason. They pay insurance premiums or their employers oftentimes pay very high insurance premiums so they can get help with the cost of that drug.

Second, I would just go back to the point that we offer free drugs, millions and millions of dollars in free drugs and copay assistance to patients. So, I'd like to think there's a safety net for almost everyone out there. Sarah, I'm happy --

MS. EMOND: No, thank you. So, you hit on a really important point because the rebate and the gross-to-net bubble gets a lot of attention. Antonio has done such

great work in this area. But it's for select classes, and so we don't see a lot of rebating in oncology. We don't see a lot of rebating in sole source. And that usually is rare disorders where there's just one drug because, again, it's market forces. There's no market incentive for the manufacturer to offer a rebate for preferred formulary placement because there is no other option. And then in oncology it's just patently unpopular to try to do any utilization management in oncology. And that's a reflection of a social value honestly, right? We want the cancer patients to be able to get access to what they need.

I did also want to mention in case it didn't come through in my earlier testimony, when we do the analysis of whether or not the price is fair, we're using estimated net price, so we're trying to get through all of this talk of rebates and discounts and who's getting what so we're able to actually look at the data that exists on the average discounts that are happening across payers, and oftentimes we're still seeing the prices are much higher than the clinical benefit patients are getting.

REPRESENTATIVE KEEFER: Can I ask one more?

MAJORITY CHAIRWOMAN RAPP: Antonio, did you have a --

MR. CIACCIA: Real quick, an overwhelming majority of the drugs are rebated in some way, shape, or

form. As a precondition for a drug to be covered within the Medicaid programs, drug makers have to volunteer to be part of the drug rebate program. So, most of the drugs that are available in the marketplace are dispensed through Medicaid, and by virtue of that, they have to be giving rebates. So, the degree of rebate are very different from drug to drug, class to class, but most drugs do see some level of rebating and discounting.

REPRESENTATIVE KEEFER: Right, which goes back to if it's going to be rebated anyway, you know, just putting that actual amount out out of the gate. And one more question, Madam Chair? So you said on average it's 10 years, $2.6 billion for a drug to come online on average. And what percentage of that is received from -- I know like Pennsylvania we give different grant dollars and academic dollars to different institutions, and you also have the NIH. Is that factoring in those dollars as well?

MS. NEVES: $2.6 billion, I'm not entirely sure if that includes NIH dollars. I don't believe it actually does. But I'm happy to talk a little bit about the NIH. You know, the NIH does very basic important research. I don't believe they're part of that $2.6 billion. And they spend far, far less on R&D than we do. Our marketing budget, which I mentioned earlier, which is about $30 billion, is about what they spend. That's the entire NIH's

budget. That's not even what they spend on drug development. That's their whole budget. We spend $90 billion, so I just wanted to get that point out.

MS. EMOND: No, no, no, absolutely. The $2.6 billion is an estimate that comes from the Tufts Center for the Study of Drug Development. And that includes the outlay from the manufacturers themselves, including like a biotech company that invested and then gets bought by a bigger company. They're factoring all of that in.

It's important to note for any economists in the room that a large portion of the $2.6 billion is actually what they call opportunity cost. It's the ability to not have invested some of the R&D money in another asset that might have been approved. And they claim that as part of the money that is spent to develop a new drug because if you dedicate your resources to developing drug A and not drug B, you've missed potentially the possibility to have a great drug with drug B. So, opportunity cost is in that $2.6 billion estimate, and so I think that's just an important caveat.

REPRESENTATIVE KEEFER: Thank you.

MAJORITY CHAIRWOMAN RAPP: Antonio, did you want to reply to the question on research?

MR. CIACCIA: Yes. I mean, the one thing that just popped out at me was I've heard three big numbers

today, one of them we had in our slides, which is the amount of rebates that are flowing through the system has now reached $166 billion. And then from the previous testimonies I heard $90 billion is being spent on R&D, another $30 billion is being spent on marketing. So, literally if you take all the R&D and the marketing and combine them, it's not nearly the amount of the amount of discounts that drug makers are passing through the system. That shows you just how significant that gap has become.

MAJORITY CHAIRWOMAN RAPP: Thank you. Our next question comes from Representative Innamorato.

REPRESENTATIVE INNAMORATO: Great. Thank you, Chairwoman. Thank you for being here.

Lauren, my first question is for you. So, you talked a lot about the aggregate of your member companies and how they've invested in new treatments and cures. I was wondering if you had the aggregate number of how much your member companies spend on CEO pay and benefit packages?

MS. NEVES: I don't have that number off the top of my head. I'm sorry.

REPRESENTATIVE INNAMORATO: Do you know how much they've spent on stock buyback?

MS. NEVES: I don't.

REPRESENTATIVE INNAMORATO: Okay. I think that's

a very important number to look at, especially when we're looking at private industry and the inflated cost of pharmaceuticals because there's been, you know, reports that there are pharmaceutical companies that are part of your member organization that are spending money to buy back their stock to return to shareholders as opposed to potentially passing on cost savings to people who need to use insulin and the like.

Do you have an aggregate number on how much you spend on lobbying?

MS. NEVES: I don't have that number in front of me right now. I certainly --

REPRESENTATIVE INNAMORATO: Okay.

MS. NEVES: -- can get it for you.

REPRESENTATIVE INNAMORATO: Okay. Because I think that would be good for our comparative to look at marketing and R&D in the context of overall expenses that you have.

Which leads me into a second question. I know in California they have introduced a bill to produce generics, and I think like a publicly owned manufacturer who is not driven by having to return values to shareholders could be something that could help realign the market and just wanted to kind of get your take on what introducing something like that into the generic marketplace would mean

for patients and end-users.

MS. NEVES: So, I'm not a generic manufacturer. I represent brand-name pharmaceutical companies, so I can't really speak to that specific aspect of the California proposal. What I would like to go back to is the lobbying question. So, you asked me specifically how much we spend on lobbying. I can tell you right now it's a fraction of what we spend on R&D, which, as I've said multiple times today, is $90 billion.

I would also say that when it comes to how much our CEOs earn, when you look at the top 20 earnings CEOs in health care, we aren't in the top 10, but PBMs are. So, I just want to again bring this back to a problem that's about the whole system, not just us.

I'll let Sarah speak about the California proposal.

REPRESENTATIVE INNAMORATO: Absolutely. And I just want to say, too, if they were sitting here, too, I would also ask them that question.

MS. NEVES: I know you would. I know you would, but they're not here, so I'm going to talk.

MS. EMOND: The generic question is a really interesting one because Lauren has mentioned this beautifully already that, again, I talk a lot about social contract, but the social contract is you get a period of

monopoly and then society benefits from that investment you made in innovation by having a cheaper price. It's unfortunate that we don't see that happening as readily as I think a lot of us would in a lot of cases.

The original patent on Humira, the biggest selling drug in the world, ran out a long time ago, but they still have a patent thicket, as it's called, around their IP that's preventing the introduction of a biosimilar. And we can have a whole other session on why no one is using biosimilars, and so I won't even dive into that.

But back to the Representative's question. The generic market is supposed to be sort of marginal cost for making the drug and a tiny bit of profit to run your business. Like that has been the way it's worked. What you see with something like a Civica Rx, which is a nonprofit generic manufacturer where large hospitals get together, is they were reacting to the fact that they were seeing shortages of drugs because there was one sole source for the generic, and then there would be a shortage. And then when it got reintroduced, they would jack up the price because they had almost like a monopoly, but they're not a brand, right? They didn't invest all of this money in the R&D, so it was raising that question.

I don't know a lot about the California

legislation. I'm interested to know why they'd want to do that and not potentially just join Civica Rx. And so that could be something that Pennsylvania examines is can we join Civica Rx, and then can we get the lower cost through their nonprofit for our Medicaid, for our State? That would just be my recommendation instead of like reinventing the wheel and trying to get certified as a generic manufacturer that's State-run, which I think would be a big task.

MAJORITY CHAIRWOMAN RAPP: Antonio, do you have anything to add?

MR. CIACCIA: Yes. Representative Innamorato, I've studied a lot about this generic market check if you will from California, and so a lot of our research, essentially everything that we started doing predicated on examining how the generic marketplace was working to drive down prices and then to see how it was manifesting itself in terms of cost on the other side of the spectrum, which is what the payers end up paying. So, what we actually see is that the generic marketplace, outside of these instances where there are unique situations with shortages, shortages inevitably do lead to price spikes and sometimes for a very small utilization for drug that not a lot of people take. Sometimes those price spikes could last for a really long time. And so in that instance I do see an opportunity for

somebody to come in with essentially good-will nature to come in and add competition back into a marketplace, essentially disrupt it.

But our research has shown that a lot of times when you see a price spike after a drug shortage, that generic marketplace is still highly competitive. You could see 20 different manufacturers of a generic drug at a different time, and there's a healthy incentive there for those generic manufacturers to constantly undercut each other to try and maneuver their way to get market share from pharmacies.

Because pharmacies get paid the same amount no matter what drug they're dispensing, the incentive of the pharmacy is to go out and buy the cheapest drug in the marketplace. So, generic manufacturers are constantly undercutting each other to try and entice the pharmacy marketplace to go buy those drugs. That way the pharmacies can increase their spread.

So, what we see is a very deficient generic --

FEMALE SPEAKER: Oh, we were doing so well. It's on his end, yeah.

MAJORITY CHAIRWOMAN RAPP: We're going to go ahead and move to then our last question from Representative Gaydos. And then if we can reconnect with Tony, he can finish what he wants to say there.

REPRESENTATIVE GAYDOS: Thank you, Chairman Rapp. You know, first of all, listening to all this, it certainly sounds like this pricing mess in the first place was caused by government and then the reaction to government sticking their hands in there. So, that's something that's always a concern to me is that, you know, price-fixing never, ever solves any problems.

The question I have is about the investment for research and development. So, $90 billion was thrown around. Out of $90 billion that is invested, how much of that goes towards drugs that actually do come to the market and, you know, what is that risk factor of pharmaceutical companies?

MS. NEVES: Sure. That's a great question. So, it is, as I said before in my testimony, a risky and complicated process. I can't break down the $90 billion for you because I think it's also incredibly intertwined.

I would say that -- so, for example, I think this number is since 2003, we've seen 143 Alzheimer's drugs go through the pipeline and fall out. There are four still in the pipeline. So, to the extent that that gives you a sense of how complicated and difficult that is, it's incredibly risky. So, there are failures, and that is a part of every business, not just ours. That's a part of manufacturing. That's a part of, you know, everything.

But because of the science and the complicated science, especially these new biologics we're developing, it's become even riskier and complicated. So, I would say that the failures are part of that $90 billion, and the failures are how we get to the successes. That's how we're eventually going to get to a cure for Alzheimer's disease.

REPRESENTATIVE GAYDOS: So, what encourages your innovation? What encourages your innovation?

MS. NEVES: The patients, the getting the cures, that's what encourages our innovation, the seeing treatments that make a difference in people's lives. That's what makes our scientists wake up every day and go to work and keep trying. If you're a bench scientist, you know that, you know, out of every 100 experiments that you do, one is going to succeed, but that one could be a cure for cancer, and that's why you keep going.

REPRESENTATIVE GAYDOS: So, ultimately, in the end, the pricing that you get --

MS. NEVES: Yes.

REPRESENTATIVE GAYDOS: -- to pay back, so really are prescription drugs really all that expensive given that that money has to go back into innovation?

MS. NEVES: I'm not sure I followed that question. Eventually, the money that we do make off of the drugs that do succeed does feed back into innovation, and

that sort of starts the cycle all over again. So, that answers your question I hope.

REPRESENTATIVE GAYDOS: Yes, it does.

MS. NEVES: Okay.

MAJORITY CHAIRWOMAN RAPP: Antonio, did you want to finish your thoughts on that question?

MR. CIACCIA: No, it's okay. Thank you.

MAJORITY CHAIRWOMAN RAPP: I want to thank you. Before I make closing remarks, I'll ask Chairman Frankel, do you have any closing remarks that you'd like to give, or questions?

DEMOCRATIC CHAIRMAN FRANKEL: I certainly appreciate those who came to testify today to give us this perspective on an issue that is incredibly complex and frustrating for many of us. And I do think that while my colleague from Allegheny County talks about the issues of innovation and not having government engage in this, government did help create this problem on the rebate issue. I think we have a responsibility to help clean that up. And one of the things just in my informal interactions with different stakeholders on this issue, there's a lot of finger-pointing all the time whether it's, you know, from the pharmaceutical manufacturers to the PBMs to the payers. We have to get beyond the finger-pointing.

But I do think that there is a role for

government to come into, and I do think that we need to take a look at the manufacturing side. I understand the need for research and development and to incentivize it, but when you do take a look at the behavior of the pharmaceutical companies with respect to, you know, the executive compensation, when you take a look at the issues that my colleague also from Allegheny County identified, the stock buyback and trying to prop up stock prices which have performed extraordinarily well, we have to be able to balance out I think on an issue that strikes so intimately in our families and our constituents that there is a role for government to play to help fix this level, that we can preserve innovation, we can preserve reasonable access to people, and I do think that, you know, some of the ideas that were thrown out today for a role for government to play for legislation, some of which is playing out in other parts of the country.

I'm not wedded just to the proposal that Mrs. Horvath brought up, which I've introduced. There may be other solutions, but we have opportunities to take a look at how these play out. Maryland has adopted that model. Maine has adopted that model. So, we'll have the opportunity to kind of review are these are at.

But I do come down to the conclusion that, you know, the idea of having a Public Utility Commission, we do

regulate things that are so meaningful to preserving quality of life and preserving life itself, whether it's access to water, gas, electricity, that pharmaceuticals play a role in that same exact space to me in terms of preserving life and quality of life for people.

So, we have a lot of work to do, and I really do appreciate all the perspectives that we had here today. And certainly for Chairwoman Rapp's interest in this and putting this hearing together, I'm very appreciative.

MAJORITY CHAIRWOMAN RAPP: Thank you, Chairman Frankel, kind words.

My thanks to all the presenters and all of your time. I know that when you compile testimony, it's not done in five minutes. And, Anthony, thank you. Antonio, thank you so very much for your contributions here. We truly appreciate it. I want to thank our IT department for being here and helping us set this up. Hopefully, the people on the overflow were able to view this downstairs. We never know how many people to expect.

And I certainly agree with Chairman Frankel. There's a lot of barriers that we see, you know, especially in prescriptions. It certainly is a huge issue with our constituents across the State of Pennsylvania. And we're always willing to look at other States' legislation and input on legislation that we could help ease the burden on

our constituents.

So, I want to thank each and every one of you, and I also want to thank the staff. They do a great job putting everything together, and I appreciate on both sides of the aisle here.

And my thanks to the public for taking the interest in being here and listening. So, I don't think this will be the last of this type of hearing because this is obviously an ongoing issue, so we definitely appreciate all of your input. Thank you so much for being here, and hopefully, we'll see you in the future. Thank you. Thank you, Members. And the meeting's adjourned.

(The hearing concluded at 11:56 a.m.)

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