

Christopher Molineaux, Life Sciences Pennsylvania
Testimony, February 25, 2020
House Health Committee Hearing on Drug Prices

Good morning Chairwoman Rapp, Chairman Frankel and members of the House Health Committee. I am Christopher Molineaux, President and CEO of Life Sciences Pennsylvania. Thank you for the opportunity to participate in today's hearing.

Life Sciences Pennsylvania represents more than 850 member entities, including small biotech companies, medical device and diagnostic makers, pharmaceutical manufacturers, patient advocacy organizations, academic research institutions, investment firms with R&D-based portfolios and myriad service providers related to the development of groundbreaking therapies, cures and technologies.

Life Sciences PA recognizes the rising cost of healthcare in the United States must be addressed. We also recognize the focus of today's hearing – the price of prescription medicines or to be more precise, the out-of-pocket costs patients pay at the pharmacy counter – is a complex issue and involves many variables.

Today, I hope to leave you with a better understanding of why patients pay what they pay for prescription medicines and how the drug supply chain from manufacturer to patient works – not in the manufacturing sense of a supply chain, but the system of payments, rebates, middlemen and other costs that affect the financial burden to the patient. I think it's important to note, however, one thing I will not be commenting on is the pricing practices of individual companies or specific products. As a health care professional that has spent time at the U.S. Department of Health and Human Services, the Blue Cross Blue Shield Association, Johnson & Johnson, and now Life Sciences Pennsylvania, I am happy to share my general understanding and experiences on this issue, but for me to comment on company-specific decisions, especially

given our large membership throughout the Commonwealth's diverse life sciences ecosystem, would be inappropriate. However, if any of the Committee members do have product or company-specific questions, I am happy to follow-up with our member companies on those issues and ensure your questions are answered.

Today, much attention is focused on the cost of prescription medicines, which account for approximately 10-14% of nationwide healthcare costs¹ – a number that has remained consistent since 1960. The real issue is the out-of-pocket costs patients pay at the pharmacy counter – an issue that is related to, but not entirely the result of, the list price of a prescription medicine.

As you can see from this chart, courtesy of the Wall Street Journal, there are many intermediaries between the manufacturer and the patient. This is generally referred to as the supply chain and is comprised of a number of different players including pharmacy benefit managers (PBM), insurance companies, pharmacies and wholesalers.

Drug manufacturers sell to wholesalers, such as AmerisourceBergen or McKesson, at a small discount to their list price. Wholesalers then sell it to the pharmacy, who subsequently sell it to the patient. If this were a "normal product," like potato chips, that would be the end of the transaction.

However, what the patient pays at the pharmacy counter is the result of a proprietary negotiation process between the patient's insurer, a PBM, whom the insurer hires, and the drug manufacturer. Drug manufacturers work with the PBMs because they want to ensure their drugs are accessible via a formulary. PBMs negotiate rebates that it will receive from the

¹ Altarum Center for Value in Health Care, *Health Sector Economic Indicators*, January 2019
https://altarum.org/sites/default/files/uploaded-publication-files/SHSS-Spending-Brief_January_2019.pdf

drug manufacturer at varying levels based, in part but not exclusively, on the list price. They may pass some or all of those rebates along to the health insurance provider. Three large PBMs (Express Scripts, CVS Health, and OptumRx – owned by United Healthcare) control approximately 75% of the market. The PBM also negotiates with the pharmacy over the reimbursement for drugs and dispensing fees. Those negotiations/cost are part of what determines what the patient's out of pocket costs will be at the pharmacy.

In essence, the out-of-pocket costs the patient pays has less to do with the list price of the drug, and more to do with what the insurer decides to cover, what the patient out-of-pocket limits are in their specific policy and how much of the PBM rebate will be passed-on to the consumer. As I noted earlier, the cost of prescription medicines has remained relatively constant as a total percentage of overall health care spending, but what has changed significantly is insurance benefit design.

You heard today from different testifiers about what's going on in other states and other proposals to "fix" or address this issue. However, the one option that was not raised is addressing insurance benefit design. This is an issue that the Pennsylvania General Assembly has the ability to address and modify...insurers operate solely within the borders of the Commonwealth. If you want to make changes to what consumers are charged or what they pay at the pharmacy counter you can address that by determining what insurance benefit design looks like for your constituents.

From the institution of Medicare Part D, to the Affordable Care Act, and many other policy changes before and after, there have been many developments to make care more affordable and accessible. However, as insurers have felt more of that squeeze, they have had to look for other revenue streams to bolster their bottom line. Given how the pricing/rebate system is

perverse-designed, higher list prices benefit every component in that supply chain – except for the end user, the patient.

In fact, this system is in the process of more consolidation, CVS Health (one of the largest providers of pharmacy services) just acquired Aetna (the #3 largest health insurer in the US) for \$69 billion in cash. Cigna paid \$52 billion to acquire Express Scripts. When a health insurer and PBM merge, who controls whom? If you're an optimist you might think that this type of merger would allow insurance companies to take a larger role over drug purchases and spending to get the best deal and keep premiums lower. However, PBMs generate more revenue and higher profit than insurers. In the Aetna example given above, Aetna reported revenue of \$60.5 billion and profits of \$1.9 billion in 2017. However, CVS PBM business alone generated \$130.6 billion in revenue and profits of \$4.8 billion.

In examples such as this we might see insurers adjust their strategies to pursue PBM type profits and not the other way around.

All that aside, I do think it is important to help explain what happens before the chart I just described.

Pennsylvania has more than 2,800 life sciences establishments. Of those 2,800 entities, more than half – 52 percent -- employ 10 people or fewer as documented in a 2017 study that was conducted by KPMG. This community is predominantly start-up in nature and is very fragile as it can take more than 2 billion dollars and more than 10 years to bring a new medicine to market. The likelihood of success in our industry is low – almost 90 percent of the new drug applications filed with the FDA fail to receive approval.

As it turns out, human biology is still very complicated. Even as we have seen significant strides made in curing disease – Hepatitis C therapies have cure rates above 90%, the U.S. death rate for HIV & AIDS has fallen nearly 85% and cancer death rates in the U.S. have fallen 23% - we know there are still millions of patients around the world with unmet medical needs. These companies, both small and large, and the people they employ are working hard to find groundbreaking therapies and cures for patients. The biopharmaceutical industry reinvests more in research and development -- 21.3% -- than any other industry in the country. Many companies will work tirelessly for the better part of a decade only to find that they must start all over again – and all the resources they just poured into their work, those are all sunk costs. Even with those odds, the United States, thanks to its scientific leadership, dogged persistence and (perhaps most important) its free-market system, is the undisputed leader in innovation, producing 57% of all new medicines in the world.

There are good policy proposals that could potentially address patient out of pocket costs, but there are others that manage to put the crosshairs on only one part of the issue that would have significant unintended consequences on other parts of the ecosystem.

Some of you may be familiar with H.R. 3, the Pelosi Drug Pricing Plan, recently by the U.S. House of Representatives. It caps some of the patient out-of-pocket costs which Life Sciences PA is generally supportive of, however, it oversimplifies the complicated pricing process I just described without recognizing the serious implications it could have on investment into the innovation and drug discovery part of the process I detailed earlier.

Additionally, the Pelosi Drug Pricing Plan also has a seemingly attractive provision in it: international drug price indexing. A provision of the bill would peg U.S. drug prices to the price paid in other countries with government run health systems. While this sounds like a very

attractive idea, this again goes straight to only one part of the drug delivery supply chain – the drug developer. This provision is expected to drastically cut investment into development resulting in potentially 56 fewer medicines in the next 10 years with the biggest impact projected to be in the cancer cure discovery (16 treatments).²

The issue of patient out of pocket costs is not a problem easily resolved and often well-intended fixes lead to detrimental unintended consequences – many of those fixes have gotten us to where we are today with such a complicated system. It is good that we are having this conversation as I am always eager to discuss ways in which our industry can best meet the needs of the patient.

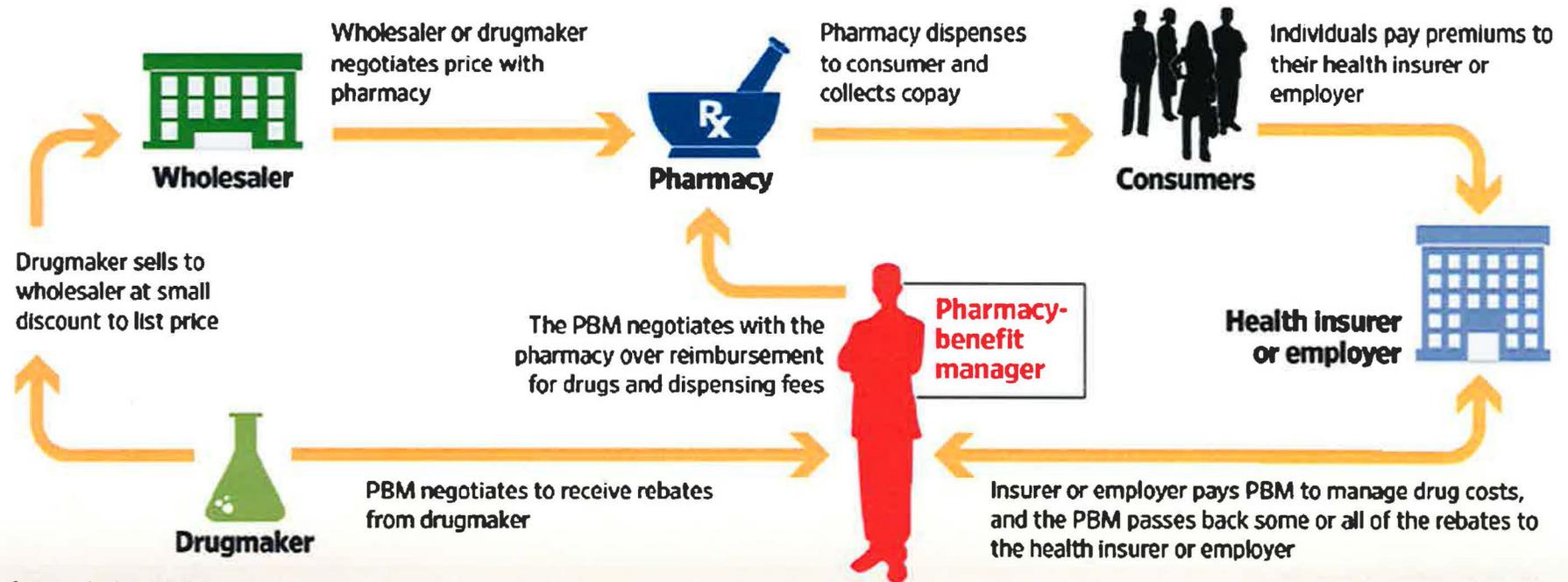
Thank you again for your time and consideration.

I am happy to answer any questions.

² Vital Transformation, *H.R. 3 – International Reference Pricing Calculating the Impact on the U.S. BioPharmaceutical Innovation Ecosystem*, November 21, 2019
http://vitaltransformation.com/wp-content/uploads/2019/11/PhRMA-Deck_v6.11.21.19-FINAL.pdf

How Drug Distribution Works

A complex supply chain determines how prescription drugs are paid for in the U.S.



Sources: Avalere Health

THE WALL STREET JOURNAL.