Chairwoman Rapp and members of the Committee, my name is Lauren Neves and I am here on behalf of the Pharmaceutical Research and Manufacturers of America. We represent the country’s leading innovative biopharmaceutical research companies devoted to discovering and developing medicines that enable patients to live longer, healthier and more productive lives. The biopharmaceutical sector is one of the most research-intensive industries in the United States — since 2000, PhRMA member companies have invested more than $900 billion in the search for new treatments and cures, including an estimated $79.6 billion in 2018 alone.

Research is at the heart of our industry. America leads the world in medical innovation, with a market-based health care system, strong protections for intellectual property and other policies that promote investment in new discoveries. And, that translates to hope for patients. We are in a new era of medicine where breakthrough science is transforming patient care and making tremendous progress against some of the most complex and difficult to treat diseases of our time. For example, Hepatitis C is now curable in most patients. Also, new medicines have changed the way we treat high cholesterol, which impacts 53% of Pennsylvanians, leading to a 36% drop in the death rate since 2000.\(^1\) And, we recently saw the biggest single-year drop in cancer mortality ever according to a new report from the American Cancer Society.\(^6\)

Those are just the medicines that we have today. The future has never been brighter with approximately 8,000 medicines in clinical development,\(^{ii}\) 74% of which have the potential to be first-in-class treatments.\(^ix\) In 2015 are more than 47,000 Pennsylvanians participating in clinical trials,\(^y\) hoping that they are part of the development of an effective treatment for what ails them. The process to bring a drug to market is risky and complicated, taking an average of 10 years, and $2.6 billion to research and develop new medicines.\(^vi\)

Those drugs are being developed by Americans here in America, including here in Pennsylvania — the biopharmaceutical industry is a vital part of the state’s economy. Nearly 254,000 Pennsylvanians worked in jobs supported by the pharmaceutical industry in 2015, and those individuals were paid nearly twice the average salary in the state. The industry supports other segments of the economy as well — biopharmaceutical construction spending amounted to over $2.5 billion in Pennsylvania between 2012 and 2017, including at least 22 major projects to build new or upgraded R&D and manufacturing plants in such places as Collegeville, Swiftwater, Exton, Pittsburgh, King of Prussia and Warminster.\(^vi\)

While medical innovation has made the United States a world leader in the discovery of new medicines, these treatments won’t benefit patients who can’t get them. We know that for far too many Pennsylvanians, the health care system is not working. There are no easy solutions, but patients here in Pennsylvania need real leadership from everyone involved in our health care system to make it work better.

1. **Prescription medicines represent a small portion of health care spending and are not the largest driver of growth.**

We believe affordability for patients and the health care system are paramount, prescription medicines are not driving growth in health care spending. After discounts and rebates, brand medicine prices grew just 0.3% in 2018.\(^viii\) Compared to other segments of the health care system, growth in drug spending is relatively small — between 2009 and 2018, both hospital care and physician services grew far more.\(^x\) In fact, prescription medicines contribute only 14% to overall health care spending, nearly half of what hospital care contributes, and less than physician services or nursing homes.\(^x\)
2. Nearly half of every dollar spent on medicines goes to someone who doesn’t make them.

While patient costs are growing, our supply chain has grown more complicated. There are now entities, including pharmacy benefit managers, who negotiate steep discounts and rebates on behalf of payers. An analysis recently released by the Berkley Research Group found that:

- Because of discounts, rebates, fees and other price concessions, nearly half of all spending on both retail and non-retail brand medicines is going to stakeholders other than the companies who research, develop, and manufacture the medicines.
- The amount our companies are receiving from the sale of brand medicines increased, on average, 2.6% annually, between 2015 and 2018, a rate roughly in line with inflation.
- The amount health care providers, including hospitals and pharmacies, are retaining from the sale of brand medicines doubled between 2013 and 2018.

In 2013, about a third of spending on drugs went to someone other than a company that made the drug. But since then, supply chain and other entities have received a larger and larger share of total spending through discounts, rebates, fees and other price concessions. Over five years, the share others in the supply chain collected increased by nearly 13%. Given this trend, the study author believes that over the next few years, these lines could cross, meaning that manufacturers may end up receiving less than other entities. Rebates and discounts have doubled to almost $166 billion just in the last 6 or 7 years. For certain medicines used to treat chronic conditions like asthma, high cholesterol, Hepatitis C, and diabetes, these discounts and rebates can reduce list prices by as much as 30 to 70%. As payers and pharmacy benefit managers use their significant leverage to demand lower prices for drugs, patients continue to pay more at the pharmacy counter. Everyone in this scenario is winning, except for the patient.

3. Patients do not benefit from negotiations in the market place and continue pay high out-of-pocket costs.

Often, what patients pay is based on list prices, not net prices inclusive of the rebates and discounts that their insurance companies receive. More than half of commercially insured patients’ out-of-pocket spending for brand medicines is based on the full list price and cost sharing for nearly 1 in 5 brand prescriptions is based on list price. In some instances, a patient may even pay more than their insurer for a drug, if the rebate is particularly large. Some payers have claimed that sharing discounts with patients would cause premiums to spike, but that is not true – sharing savings with patients would increase premiums by 1%, at most. Research has shown that passing through rebates and discounts could improve affordability, as well as patient adherence. For example, sharing 100% of rebates with diabetes patients would reduce their out-of-pocket costs by 40%, or $791 per person, per year. It would also reduce avoidable costs on other types of health care services by $435 million each year.

This relief is desperately needed – health insurance deductibles have increased 360% since 2006, and the number of plans that have deductibles as part of their benefit design has increased to 52%. That means that patients are having to pay more, for longer, at the beginning of the year, to get any type of help with their out of pocket costs at all. Between 2002 and 2017, the number of plans that have at least four tiers of cost sharing has increased from 3% to 44%. Increased use of 4 or more tiers by plans means that more patients are subject to what is commonly higher cost sharing on the specialty tier. Medicines on the specialty tier are also more likely to be subject to coinsurance based on list prices, which means those patients do not benefit from the savings plans receive.

4. Policymakers should pursue commonsense reforms that prioritize patient affordability and reduce misaligned incentives in the current system.
Policies that would allow the government to dictate the price of a drug threatens innovation, the jobs that drive innovation, and patient access to medicines. We have clear evidence of this — in foreign countries where the government sets prices for medicines, like the United Kingdom and Germany, they have access to far fewer medicines than in the U.S. There is clear evidence from other countries of the negative impact from this type of policy change. In 1986, biopharmaceutical R&D investment in Europe was 24 percent higher than in the United States. Today, after price controls, Europe trails the United States by over 40 percent.\textsuperscript{xvii,xviii}

We believe we need solutions that can help patients pay less for their medicines, not increase barriers to access and reduce their hope for innovative medicines.

- First, we must require that insurers and PBMs must share rebates and discounts they receive from drug companies, with patients.
- Second, in some cases, health insurance companies are not allowing the coupons manufacturers provide to patients to count towards deductibles or other cost-sharing burdens, meaning patients could be paying thousands more at the pharmacy than they should be. We need to end this practice and ensure that patients are getting the full benefit of programs meant to help them afford their medicines.
- Third, patients should have more choices when it comes to their medicine coverage. Health insurers should offer at least some health plan options that exclude medicines from the deductible and offer set copay amounts instead of forcing patients to pay an amount based on the full list price of their medicines.

Additionally, to help provide patients with more transparency about medicine costs, PhRMA member companies created the Medicine Assistance Tool, or MAT. The platform provides patients, caregivers and health care providers with information to help them connect to financial assistance programs for the medicines patients need. MAT also links to member company websites, referenced in company direct-to-consumer television advertising, where information about the cost of the prescription medicine is available.

Innovation depends on having a U.S. market that is free, competitive, and predictable. These solutions have the potential to vastly improve that market and help patients afford their drugs and thrive without financial hardship. We look forward to working with the Committee, and other stakeholders, to create such change.

\textsuperscript{i} Centers for Disease Control and Prevention.
\textsuperscript{iii} Adis R&D Insight Database. May 2019.
\textsuperscript{v} WeWorkForHealth.org/our-impact/Pennsylvania
\textsuperscript{vi} DiMasi JA, Grabowski HG, Hansen RW. Innovation in the pharmaceutical industry: new estimates of R&D costs. J Health Econ. 2016;47:20-33. Previous research by DiMasi and Grabowski estimated the average R&D costs in the early 2000s at $1.2 billion in constant 2000 dollars (see DiMasi JA, Grabowski HG. The cost of biopharmaceutical R&D: is biotech different? MDE Manage Decis Econ. 2007;28:469-479). That estimate is based on the same underlying survey as estimates for the 1990s to early 2000s reported here ($800 million in constant 2000 dollars) but is updated for changes in the cost of capital.
\textsuperscript{vii} WeWorkForHealth.org/our-impact/Pennsylvania
\textsuperscript{viii} IQVIA, January 2019.
\textsuperscript{ix} Centers for Medicare & Medicaid Services (CMS). National health expenditure data.
\textsuperscript{x} Source: PhRMA analysis of CMS National Health Expenditures data, Altarum Institute study and Berkeley Research Group study.
\textsuperscript{xi} Berkeley Research Group
\textsuperscript{xii} Fein AJ; Drug Channels Institute
\textsuperscript{xiii} IQVIA. May 2018.


Medicines Are Transforming the Treatment of Devastating Diseases

HEPATITIS C
The leading cause of liver transplants and the reason liver cancer is on the rise – is now curable in more than 90 percent of treated patients.*

CANCER
New therapies have contributed to a 27% decline in cancer death rates since the 1990s. The chance a cancer patient will live 5 years or more has increased 41% across all cancers since 1975.**

HIGH CHOLESTEROL
New drugs have revolutionized high cholesterol treatment. Since 2000 alone, the death rate from heart disease has declined by 36%.***

*Source: U.S. Food and Drug Administration
**Source: American Cancer Society
***Source: Centers for Disease Control and Prevention
Developing New Treatments and Cures Is a Complex and Risky Undertaking

On average, it takes more than 10 years and $2.6B to research and develop a new medicine.*

BETWEEN 1998 AND 2014

Unsuccessful Attempts

146
Alzheimer's Disease**

96***
Melanoma

167****
Lung Cancer

Successful Attempts

4
Alzheimer's Disease

7
Melanoma

10
Lung Cancer

Just 12% of drug candidates that enter clinical testing are approved for use by patients

*Source: DiMasi JA, Grabowski HG, Hansen RW. Innovation in the pharmaceutical industry: new estimates of R&D costs. J Health Econ. 2016;47:20-33. Previous research by DiMasi and Grabowski estimated the average R&D costs in the early 2000s at $1.2 billion in constant 2000 dollars (see DiMasi JA, Grabowski HG. The cost of drug development from discovery to approval. Nat Rev Drug Discov. 2003;2:93-106). This estimate is based on projections using survey of estimates for the 1990s to early 2000s, assuming an inflation rate of 2% per year. In constant 2006 dollars, this is updated for changes in the cost of capital.


The Biopharmaceutical Industry’s Impact on Pennsylvania’s Economy

More than 253,876 Jobs

ECONOMIC OUTPUT FROM INDUSTRY

$67.3B

$4.2 Billion
In Revenue Generated

Annual average compensation of $126,493 PER DIRECT JOB is more than twice the average annual compensation for all other jobs.
After Discounts and Rebates, Brand Medicine Prices Grew Just 0.3% in 2018
Medicine Spending Is Not the Biggest Driver of Health Cost Growth

Cumulative Spending Growth Over 10 Years (in Billions), 2009-2018

- **Total National Health Expenditures**: $1,151.3
- **Hospital Care**: $413.8
- **Physician and Clinical Services**: $230.3
- **Nursing Home, Home Health, and Related**: $134.7
- **Health Insurance Administrative Costs**: $126.1
- **Retail Prescription Medicines**: $91.8
- **Dental and Other Professional Services**: $64.7

*Total national health expenditures amount does not reflect all expenditures, but all categories are shown. Source: Centers for Medicare & Medicaid Services (CMS), National Health Expenditure Data.*
Prescription Medicines Represent Just 14% of Total Spending

U.S. Health Care Spending, 2018

- Admin Costs
- Home Health & Nursing Home Care
- Prescription Medicines
- Physician & Clinical Services
- Other**
- Dental Services
- Hospital Care

Source: PHMMA analysis of CMS National Health Expenditures data, Altarum Institute study and Berlex Research Group study.
**Supply chain entities involved in bringing medicines from manufacturer to patient, including wholesalers, pharmacies, PFSAs, and healthcare provider facilities.
New analysis finds manufacturers are retaining an increasingly smaller share of total spending on brand prescription medicines.

- **Nearly 50%**
  - Share of brand spending that went to payers, the supply chain and others in 2018

- **2.6%**
  - Annual increase in brand spending received by manufacturers, on average, between 2015 and 2018

- **2x**
  - Growth in amount retained by hospitals, pharmacies and providers between 2013 and 2018
Nearly half of spending on brand medicines went to supply chain and others in 2018.

Although total brand medicine spending at the point of sale increased from $269B in 2013 to $440B in 2018, the share of spending retained by manufacturers declined by 12.5 percentage points.
Negotiated Savings Often Do Not Make Their Way To Patients

More than half of commercially insured patients' out-of-pocket spending for brand medicines is based on the full list price.

Cost sharing for nearly 1 in 5 brand prescriptions is based on list price.

Source: IQVIA, May 2018
Patients Who Pay Based on Undiscounted List Prices Do Not Directly Benefit From Rebates and Discounts

**Cost to Patient (based on list price)**
Patient has a 25% coinsurance
$400 \times 25\% = $100

**Cost to Plans (based on net price)**
Net Price ($140) – Cost Sharing ($100) = $40

Patients can end up paying a greater share of total cost than their health insurers pay.
Sharing Negotiated Discounts with Patients Would Increase Premiums About 1%

Certain commercially insured patients could save $145 to more than $800 annually.

<table>
<thead>
<tr>
<th>PLAN TYPE</th>
<th>Change in Plan Costs $</th>
<th>Change in Plan Costs %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional PPO</td>
<td>$0.82</td>
<td>0.2%</td>
</tr>
<tr>
<td>Copay HDHP*</td>
<td>$2.62</td>
<td>0.7%</td>
</tr>
<tr>
<td>Coinsurance HDHP</td>
<td>$3.84</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

Net Plan Per Member Per Month Spend:
- Traditional PPO: $433.91
- Copay HDHP*: $374.41
- Coinsurance HDHP: $372.89

NOTE: Plan costs include medical and pharmacy claims.
*Copay high-deductible health plan.
Passing Through Rebates and Discounts Could Improve Affordability and Adherence, and Reduce Avoidable Costs

Sharing 100% of rebates with diabetes patients in the commercial market would:

- Reduce patients’ out-of-pocket costs on diabetes medicines by 40%, or $791 per person, per year.
- Reduce employers’ disability, sick days and medical spending.
- Reduce health plans’ medical services use and overall spending by $435 million each year.

Despite Slow Cost and Price Growth for Medicines, Patient Costs are Rising

2006-2018

Deductibles have increased 360% since 2006

Percentage of Plans With Deductibles for Prescription Drugs

2012

23%

2017

52%

+126%

Plans Increasingly Subject Certain Medicines to Higher Cost Sharing

Share of Workers in Plans With 4 or More Cost Sharing Tiers*

- 2004: 3%
- 2006: 5%
- 2008: 7%
- 2010: 13%
- 2012: 14%
- 2014: 20%
- 2015: 23%
- 2016: 32%
- 2017: 44%

Fourth Tier
Average coinsurance: 27%
Average copay: $101
PhRMA Supports State-Level Solutions

- Share the Savings
- Make Coupons Count
- Offer Lower, More Predictable Cost-Sharing Options
MAT is a web platform designed to help patients, caregivers and health care providers learn more about some of the resources available to assist in accessing and affording medicines. MAT includes 900+ Public and Private Programs made up of patient assistance programs to cost-sharing assistance programs.

Step 1
Visit MAT.org and select whether you are a patient, loved one or health care professional.

Step 2
Enter the name of the medicines you, your loved one or your patient are prescribed.

Step 3
Enter your personal information or that of your loved one or patient.