Testimony to Senate Health and Welfare Committee on S. 175

Mark Hage, Vermont-NEA/January 26, 2018

Good morning. My name is Mark Hage. I'm the Director of Benefit Programs at Vermont-NEA. As you may know, I'm also a trust administrator for the Vermont Education Health Initiative (VEHI), a position I have held for 16 years. But my testimony today is exclusively on behalf of Vermont-NEA, not VEHI.

In respect to S.175, Senator Tim Ashe, one of the bill's sponsors, was quoted in the press as saying that prescription costs are "eating everyone's lunch." I concur with that assessment, but it may be too kind. Most days it feels like the pharmaceutical industry is eating everyone's breakfast and supper, too.

Vermont-NEA strongly endorses S.175; the legislation is both bold and prudent. And it is necessary. Since we can't import Canada's drug prices and are blocked by powerful political and economic forces at present from tightly regulating prescription costs, we should judiciously avail ourselves of targeted, lower-cost prescriptions while we continue the work in Vermont and nationally to enact systemic reforms on how we pay for prescriptions and health care generally.

The idea of importing drugs from Canada or elsewhere has been irrationally controversial in the United States for some time. The members states of the **European Union**, by contrast, have sanctioned and regulated this commercial practice (known as "parallel pharmaceutical trading") for 40 years, and it is an important part of national policy in some countries, including the United Kingdom and Germany, and involves all sectors of the pharmaceutical manufacturing and distribution chain.

Maximizing the purchasing power of prescription drug consumers in Vermont to achieve cost savings is enlightened, rational public policy. S. 175 will lower the cost of prescription drugs, bringing a measure of financial relief to school employees and school districts and helping to advance the goal of achieving affordable, equitable health care for all.

One of my union members, a support-staff employee now enrolled in a VEHI high-deductible plan as of January 1, left a pharmacy during the first week of January **without** his medication because he could not afford the **$890** cost he had to pay **up front** before being eligible for reimbursement from his school district for approximately $600 of that bill. He is not alone.

Everyone knows that prescription drugs are overpriced and unaffordable – for individuals, for families, for employers, for our municipal, state and federal governments. Their costs take a heavy toll on family and public budgets, and on the medical well-being of patients who can't pay for their medications or who cut back on prescribed dosages because of cost (please see **page 5** for findings from a 2016, Consumer Reports' survey on the impact of high-cost drugs on people's quality of life).

According to a 2015 investigative report in *The Atlantic*, many states have passed rules that ration access to high-cost, Hepitatus C drugs like Sovaldi and Harvoni for Medicaid patients unless they have advanced fibrosis or liver scarring, or have mandated that these patients take urine tests for drugs and alcohol before prescribing and paying for the medications. These practices are inconsistent with medical and FDA guidelines.[1]

[1] *The True Cost of an Expensive Medication*, Olga Khazan, The Atlantic, September 25, 2015, https://www.theatlantic.com/health/archive/2015/09/an-expensive-medications-human-cost/407299/.

The United States is unique among industrial nations in that it both grants pharmaceutical companies patent monopolies and then allows them to sell their drugs at whatever price they determine.

Dean Baker, co-director of the Center for Economic and Policy Research, points out, *"…other wealthy countries also grant patent monopolies, which are required by international agreements, but they have some form of price control which limits what companies can charge. For this reason, drug prices in other wealthy countries are typically* ***around half of the price*** *in the U.S."*[2]

U.S. drug companies market their products at prices that can be hundreds of times a free market price. The Hepatitis C drug **Sovaldi**, for example, can have a list price of $84,000 for a three-month course of treatment. The drug, in many cases, cures patients, so its medical efficacy is not in doubt. But it doesn't cost anywhere near $84,000 to manufacture Sovaldi. In India, for example, there is a high-quality generic equivalent that costs **$200** for three months of treatment.

This price-gouging phenomenon is pervasive, and includes high-cost HIV and cancer medications. The table on **page six** captures this, and underscores some of the cost disparities internationally for Hepatitus B and C medications.

Large drug manufacturers not only profit massively from patent monopolies and the absence of price regulation, but they stash large sums of their earnings in foreign tax havens. At the end of 2015, according to Citizens for Tax Justice, 20 U.S. businesses alone had **$1 trillion** in "unrepatriated income" in offshore accounts (OSAs**). Five of them were pharmaceutical corporations** – Pfizer ($193.5 billion in OSAs), Merck ($59.2 billion in OSAs), Eli Lilly ($26.5 billion in OSAs), Abbvie ($25 billion in OSAs), and Bristol-Meyer Squibb ($25 billion in OSAs).

Six pharmaceutical corporations were listed among the top 28 businesses that had **increased** offshore profits by at least **$2 billion** between 2014 and 2015: Pfizer ($17.7 billion increase), Gilead Sciences (the manufacturer of Sovaldi; $12.9 billion increase), Johnson & Johnson ($4.6 billion increase), Amgen ($3.3 billion increase), Celgene ($2.1 billion increase), and Abbvie ($2 billion increase).[3]

The Associated Press and Equilar, which analyzes executive data of companies on the S&P 500, published the top 20 executive earners in 2016 in the health care industry. Twelve – the names in yellow below – are CEOs of major drug companies (these compensation figures include salary, bonuses, stock and stock option awards, and other financial benefits):

1. Leonard S. Schleifer, Regeneron Pharmaceuticals, $47,462,526
2. Jeffrey M. Leiden, Vertex Pharmaceuticals, $28,099,826
3. Larry J. Merlo, CVS Health, $22,855,374
4. Robert J. Hugin, Celgene, $22,472,912
5. Alex Gorsky, Johnson & Johnson, $21,128,866
6. Michael F. Neidorff, Centene, $20,755,103
7. Alan B. Miller, Universal Health Services, $20,427,309
8. Kenneth C. Frazier, Merck & Co., $19,898,438

[2] *Drugs are Cheap: Why Do We Let Governments Make Them Expensive?,* Remarks by Dean Baker, Co-Director, Center for Economic and Policy Research (CEPR), The Svedberg Seminar, Uppsala University, February 13, 2017.
[3] *Fortune 500 Companies Hold a Record $2.4 Trillion Offshore,* Report by Citizens for Tax Justice (CTJ), https://ctj.org/pdf/pre0316.pdf, March 3, 2016.

9. Miles D. White, Abbott Laboratories, $19,410,704
10. John C. Martin, Gilead Sciences, $18,755,952
11. Richard A. Gonzalez, AbbVie, $18,534,310
12. Heather Bresch, Mylan, $18,162,852[4]
13. David M. Cordani, Cigna, $17,307,672
14. Mark T. Bertolini, Aetna, $17,260,806
15. George A. Scangos, Biogen, $16,874,386
16. Robert L. Parkinson, Baxter International, $16,648,750
17. John C. Lechleiter, Eli Lilly & Co, $16,562,500
18. Marc N. Casper, Thermo Fisher Scientific, $16,307,079
19. Robert A. Bradway, Amgen, $16,097,714
20. George Paz, Express Scripts Holding, $14,835,587[5]

My apologies if this is data feels like "overkill." But my point is clear, I hope: the major pharmaceutical companies will not be sunk or crippled financially by S.175.

Vermont-NEA supports the transparency provisions in S.175, including that which requires health insurers to provide information about the impact of prescription drug spending on premium rates. My experience is that too many workers, patients and employers have no idea how much prescriptions are fueling premium growth, particularly **specialty drugs**. That information, as well as estimated savings from the importation program for all affected parties, should be disseminated widely in the state on an annual basis.

Along these lines, the bill's requirement that a publicly available source be created for listing the prices of imported prescription drugs is very important. There is too much secrecy, opaqueness, and confusion around the cost of prescription drugs, and it's unnecessarily difficult to get cost information for drugs or medical treatments generally.[6] Knowing the price of drugs also gives patients a financial incentive to purchase lower-cost medications, either domestically sourced or imported. Further, pharmacies should be required to notify patients of the availability of lower-cost, imported prescriptions.

In Section 4637 of the bill, "Notice of Introduction of New High-Cost Prescription Drugs," we suggest adding language that obligates drug manufacturers to disclose research and development costs, and the prices charged in other countries. We also recommend, if this is not already the intent of S.175, that the names of the drug manufacturers introducing new high-cost medications be published in conjunction with the drugs in question and their prices. Additionally, if a manufacturer establishes licensing agreements with another country or commercial entity outside of the U.S. that permits a generic equivalent of a high-cost drug to be produced and sold, that this, too, be shared with the state, along with the price of the generic.

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[4] Mylan, in 2013, received $4.2 million in incentives from the Vermont Economic Progress Council (VEPC) to build a new facility in St. Albans (http://www.samessenger.com/mylan-completes-expansion/). In 2016, it hiked the price of **Epipen** five-fold ($103 in 2009) to $608. The company agreed in 2017 to pay a fine of $465 million for overcharging the government for Epipen (https://www.reuters.com/article/us-mylan-epipen/mylan-u-s-finalize-465-million-epipen-settlement-idUSKCN1AX1RW).

[5] *Paycheck envy? Check out how much pharma and health care CEOs made last year,* https://www.statnews.com/2016/05/26/ceo-pay-pharma-health-care/, May 26, 2016.

[6] See *http://auditor.vermont.gov/sites/auditor/files/documents/Final%20VHCURES%20Report%206.25.2014.pdf*.

The union also believes it would be beneficial over the long term for the state to investigate sources it can consult and direct Vermonters, employers, insurers, and government officials to for trusted, research-based findings on the clinical value and cost effectiveness of new high-cost drugs. Important work of this nature is being done now, for example, by the Institute for Clinical and Economic Review in Boston and by Evidence-based Practice Centers in the country.[7]

S.175's requirement for a "robust" auditing system for the importation program is vital. If it would be helpful, Vermont-NEA can recommend a company that has extensive auditing and contract negotiations' experience in the pharmacy arena and, thus, could be able a valuable resource.

Vermont-NEA would be happy to participate in any formal body created to advise the state on the creation of an outreach and marketing plan to generate awareness of the importation program required by S. 175, and the union will do its utmost to raise awareness of the program with school boards, school employees and their families, educational retirees, and other unions and their members.

Finally, the Centers for Medicare and Medicaid Services (CMS) predicts that prescription drug spending nationally will grow an average of **6.3 percent per year** between 2016 and 2025, peaking at **7.6 percent** this year.[8] Clearly, there is no end in sight to the unrelenting cost pressures linked to prescription drugs.

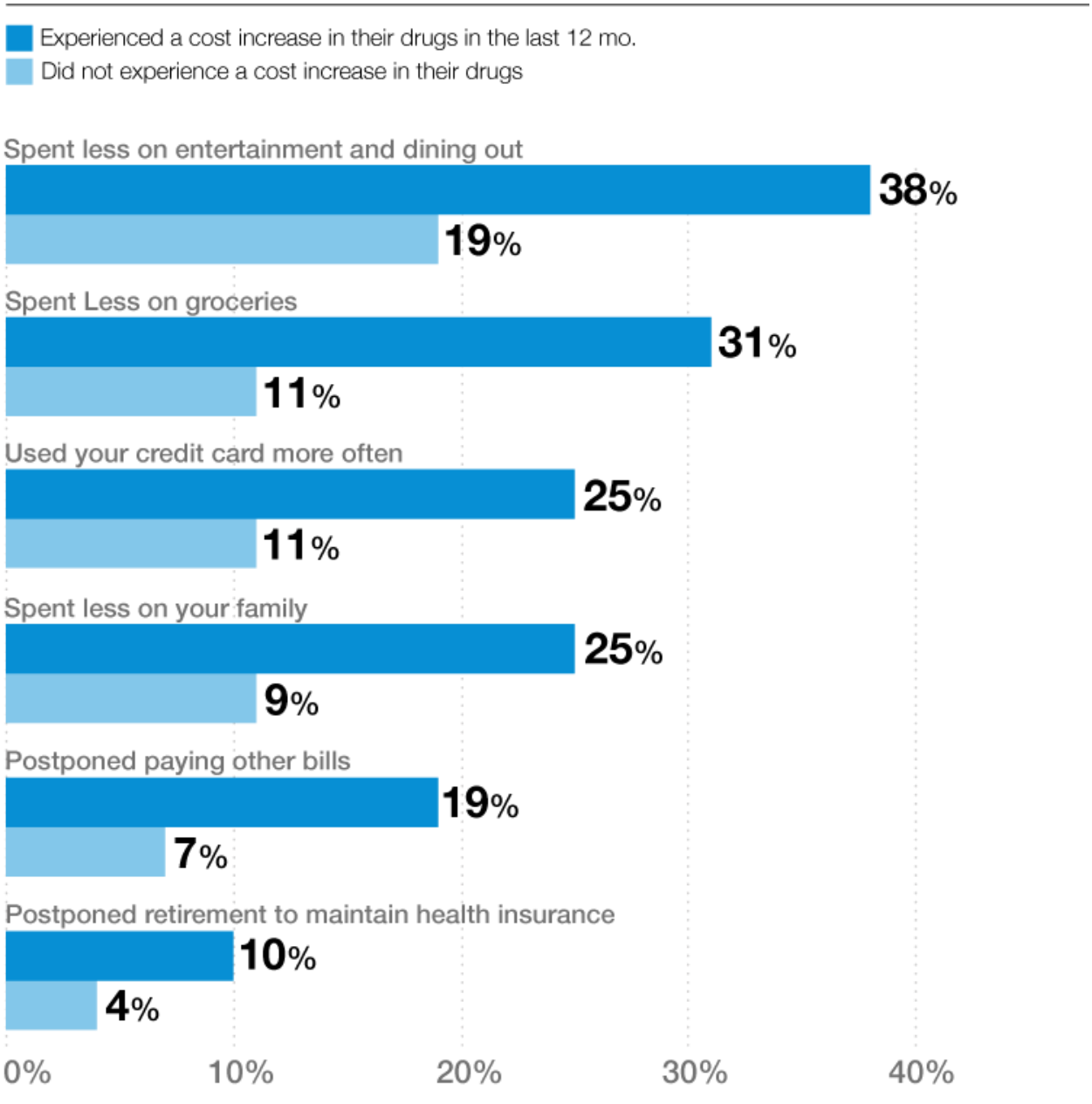
So S.175 is an important step in the right direction. It's the kind of change that will make a difference in the lives of many working families and their employers, and for the state, and it is the kind of change that can help create a public space for broader thinking and, ultimately, action on fundamental, systemic changes that are needed to control health care costs, improve quality and transparency, make care more patient centric, and ensure that access to health care is universal and affordable. Thank you.

[7] See https://www.ahrq.gov/research/findings/evidence-based-reports/overview/index.html and https://icer-review.org/.

[8] *National Health Expenditure Projections 2016-2025*, Forecast Summary, Centers for Medicare and Medicaid Studies.

WHEN DRUG PRICES RISE, QUALITY OF LIFE GOES DOWN

Consumer Reports Best Buy Drugs conducted a nationally representative telephone poll of 4,015 adult Americans in March 2016. We found that 45 percent of people regularly take a prescription drug and on average take between four and five medications. To afford those, people made adjustments in household spending (see light blue bar below). But for the three in 10 people (29 percent) who reported that they paid more money out of pocket for at least one of their drugs over the prior 12 months, the budget crunch was more dramatic (see darker blue bar).



Source: Consumer Reports Best Buy Drugs Tracking Poll 7, conducted March 10-27, 2016
* Percentages won't add up to 100 because people were able to report multiple actions taken

[9] *Is There a Cure for High Drug Prices,* https://www.consumerreports.org/drugs/cure-for-high-drug-prices/ (2016).

Table 1: Examples of Current and Target Prices of Commonly Used Drugs (USD$)		
Drug	**Current U.S. Price**	**Current Lowest Generic ***
Hepatitis B (annual cost)		
entecavir	15,111	427.00
Hepatitis C direct acting antivirals (DAAs) (3 month course)		
sofosbuvir	49,680	324
daclatasvir	50,653	153
sofosbuvir + ledipasvir	56,700	507
sofosbuvir + velpatasvir	74,760	--
HIV antiretrovirals (annual cost)		
abacavir/3TC	18,600	161
tenofovir/FTC	21,120	67
efavirenz/TDF/FTC	34,428	110
efavirenz	12,120	36
nevirapine	7,776	28
rilpivirine	12,900	--
atazanavir	19,872	219
darunavir	19,584	--
Cancer drugs (treatment cost)		
imatinib	106,322	790
erlotinib	79,891	1932
sorafenib	139,138	1332
lapatinib	75,161	18,603
cabazitaxel	120,613	30,810
dasatinib	10,408	1183
* From India, Thailand, Brazil or South Africa.[10]		

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[10] *1,000-Fold Mark-Up for Drug Prices in High Income Countries Blocks Access to HIV, HCV and Cancer Drugs,* by Simon Collins, reporting on analysis by Dr. Andrew Hill delivered at "2016 Glasgow HIV Congress," Oct. 24, 2016. More current data presented at the World Hepatitis Summit in Nov. 2017 showed the list price of antiviral drugs for Hep C range in price from $78 in India and $174 in Egypt, to $6,000 in Australia, $77,000 in the U.K., and $94,400 in the U.S. See: https://www.eurekalert.org/pub_releases/2017-11/wha-mcc103117.php.