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JUDICIARY COMMITTEE HEARING

IN RE: HOUSE BILL 2819

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BEFORE:
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HON. TIMOTHY HENNESSEY
HON. MARK McNAUGHTON

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I N D E X

CHAIRMAN GANNON: Welcome to the public hearing on House Judiciary Committee House Bill 2819 dealing with prescription drug prices.

This hearing arises as a result of the introduction of House Bill 2819 which really had its nexus as a result of public hearings held here several weeks ago.

During those hearings, information was presented to the Policy Committee, the Republican Caucus of the House of Representatives with respect to cost of prescription drugs both to the Commonwealth and the citizens of Pennsylvania.

These hearings are an attempt to get to the root of the problem with respect to skyrocketing cost of prescription drugs and what the Commonwealth of Pennsylvania can do about it.

With that said, I would like to call our first witness, Mr. John Conte, advocacy volunteer of the American Association of Retired Persons.

For the record, a copy of the transcript of this hearing will be provided to each member of the House Judiciary Committee as this is a legislative proceeding.

Welcome, Mr. Conte. You may begin when you're ready.

MR. CONTE: Thank you, gentlemen, and members of the House Judiciary Committee. My name is John Conte, and I am an advocacy volunteer for AARP in the 7th Congressional District.

I appreciate the opportunity to appear before the House Judiciary Committee today on behalf of the AARP and its 1.8 million members across the Commonwealth of Pennsylvania.

AARP is very interested in the issues raised by House Bill 2819. Prescription drug costs severely impact the costs of many older Pennsylvanians. The difficulties that rising prescription drug costs cause consumers have been well documented in the media and debates in the General Assembly and the kitchen tables all across the Commonwealth. But the background of these difficulties is not discussed as often.

We must realize there has been a fundamental change in the way healthcare is delivered in the United States over the past decade. Pharmaceutical products play a much larger role than ever before in treating and preventing serious medical conditions.

Physicians routinely prescribe medications not only to address illnesses but to combat

conditions to which patients may be susceptible in the future.

There has been a significant increase in the use of maintenance drugs, medications a patient may need to take for the rest of their lives to address a certain disease or medical condition.

There is little doubt this shift to a greater reliance on prescription drugs for healthcare has been beneficial for many people. It has reduced hospital stays and doctor visits and has generally improved the health and longevity of many people.

There have been consequences of this change. Our healthcare financing system has not kept up with this shift. Many people, particularly older Pennsylvanians who rely on Medicare as their primary medication insurance have no insurance coverage for prescription drugs. Let me say that again. Not many people, older people who rely on Medicare for their primary medical have no insurance coverage.

AARP research indicates that close to one-third of those over the age of 65 pay for medications out of their own pockets. In addition, the cost of these medications has skyrocketed making the latest innovations and prescription drugs virtually unaffordable for those who do not have a

system to pay for them.

Two years ago, AARP asked its members to fill out postcards related to a congressional mailing campaign wherein we were demanding prescription drug coverage be included in the Medicare program.

As part of that effort, we asked people to tell us of their own personal experiences with prescription drugs. Over 14,000 people filled out these cards in Pennsylvania alone. Many of them wrote their own sorry, sad stories.

The number of people with prescription drug bills considerably more than $1,000 a year was shocking; but remember, that was two years ago. Drug costs have continued to skyrocket over the past two years of rates well above prevailing inflation.

Meanwhile, many Medicare HMOs have dropped their coverage in areas all across the US leaving many older Pennsylvanians without access to insurance coverage prescription drugs.

I feel the stories that we would read on postcards today would be more desperate than two years ago.

A significant portion of the blame for this situation lies in the pricing structure of prescription drugs. We at AARP hear desperate

stories from the one-third of the population who do not have insurance coverage for prescription drugs.

But we also hear from the other two-thirds of the population who do have coverage and their message is, don't jeopardize my prescription drug plan. Who can blame them?

In many cases, they are getting prescription drugs they need for a small copay while those without coverage may be paying hundreds of dollars for the same coverage for the same prescription.

It is in this context of these dramatically different experiences for individuals that have issues raised in House Bill 2819 that should be explored. We should not punish those individuals who are fortunate enough to have worked for a company that provides them health insurance in their retirement years that includes prescription drug coverage.

But we do need to explore the questions and the differences in prices that pharmaceutical manufacturers charge the insurance companies and other favored customers and those charged individuals forced to purchase prescription drugs on their own.

House Bill 2819 offers an approach to

address this question. AARP is pleased that Chairman Gannon and other cosponsors of this legislation have begun to pursue these issues.

Our public policy book for 2002 recommends -- that states, and I quote, develop approaches to providing prescription drug coverage and/or reducing prescription drug prices that enhance access to save effective and appropriate drug therapies, unquote.

The AARP Pennsylvania office has asked AARP's policy experts at our national headquarters in Washington, D.C., to review this legislation and make recommendations based on our policy and the experiences of other states in this area.

It's a serious issue with numerous state and national policy ramifications that will take some time to explore. AARP will be glad to work with you on this issue and a larger issue in general on this bill in particular.

In conclusion, it should be stated that the issues of rapid rising prescription prices is likely to grow in importance. The fundamental changes in healthcare will not likely to be reversed anytime soon.

Reliance on prescription drugs to treat medical conditions is only likely to grow. In

addition, it is likely that insurance plans will continue either to drastically increase the cost of insurance coverage that included prescription drug plans or to eliminate these types of plans entirely.

This is likely to increase the number of people unable to obtain prescription drug coverage. We cannot allow a large portion of our population to be able -- unable to afford the form of healthcare that has become a prevailing method of treatment of many medical conditions.

AARP appreciates your willingness to discuss the issue and invite our comments. I will answer any questions you may have. Thank you.

CHAIRMAN GANNON: Thank you, Mr. Conte. Has AARP done any research with specificity as to the price differences with respect to both the drug manufacturers and drug companies charge, say, a favored customer as opposed to an individual? What do they see?

MR. CONTE: I understand your question, Representative. I don't believe we have any specific research on that topic. Should I be wrong on any of the answers, I'll be sure to follow up and distribute information to you.

CHAIRMAN GANNON: Okay.

MR. CONTE: Will that be acceptable, sir?

CHAIRMAN GANNON: That will be fine. That will be fine. Thank you very much --

MR. CONTE: Thank you, sir.

CHAIRMAN GANNON: -- for giving us the policy position of the AARP on that and support of the topic.

MR. CONTE: Thank you.

CHAIRMAN GANNON: Our next witness is Kathy Cubit, director of advocacy initiatives, the Center for Advocacy for the Rights and Interests of the Elderly.

I would also like to welcome to the panel Representative Steve Barrar from Delaware County. You may proceed whenever you are ready.

MS. CUBIT: Good morning, Chairman Gannon, members of the House Judiciary Committee, and staff. Thank you for sponsoring today's hearing about the prescription drugs and for the opportunity to present testimony.

As you mentioned, my name is Kathy Cubit; and I represent CARIE, Center for Advocacy for the Rights and Interests of the Elderly.

CARIE is a nonprofit advocacy agency. We're in our 25th year of providing advocacy

services. One of our primary services is our CARIE line. It's a free telephone service. We also have a web site where we'll answer questions on-line.

We get calls from older adults, their caregivers about all kinds of problems related to long-term care. We do options counseling and help them resolve their problems; and prescription drugs and the cost of that certainly for many older adults who are living on a limited income, it's a big problem.

According to AARP, in 2000, Medicare beneficiaries spent about $480 in out-of-pocket expenses for prescription drugs. There's a very interesting recent national study that was funded by the Commonwealth fund and the Kaiser Family Foundation.

That study documented that even though Pennsylvania has one of the largest and most comprehensive prescription drug programs in PACE and PACENET, 20 percent of low-income adults still lacked prescription drug coverage.

And about 35 percent of older Pennsylvanians and 15 percent of seniors in the PACE and PACENET program reported spending over $100 a month on prescription drugs.

The study went further and compiled data related to the impact of the cost of prescription drugs and concluded that 20 percent of older Pennsylvanians and 8 percent in the PACE and PACENET program did not fill one or more prescriptions during the year because they could not afford the costs.

Twenty-three percent of Pennsylvanians, seniors overall, and 27 percent of those in PACE and PACENET reported skipping doses to make prescription drugs last longer. So the study clearly demonstrates that cost impacts compliance regarding prescription drugs.

Finally, when askec if they spent less in the past year on basic needs such as food or utilities, 12 percent of seniors responded yes. This increased to 25 percent in the PACE and PACENET program.

The next part of my testimony I would like to talk about, just to give you a case example -- and this is a client who is 79 years old -- she has chronic pulmonary disease and severe arthritis, glaucoma, and macular degeneration among other ailments, which is common for older adults, as you know, to have multiple chronic illnesses.

Her monthly income with Social Security and

pension is slightly over the eligibility limits with PACE and PACENET. Her total monthly drug bill amounts to $325, and she also spends $190 for her Medigap policy.

She does use this new federal Together RX card but really doesn't see very many results. She also recently had to fill a prescription for antibiotics. It was only seven pills. That cost her $85.

So without any additional medical expenses, she's already spent 30 percent of her income just between her monthly prescription drugs and the Medigap policy.

She also happens to be a resident of Philadelphia. They're going to be seeing a huge steep increase in their property taxes. You can see how quickly an older adult's monthly income can be consumed by trying to maintain their health and need for prescription drugs.

It does seem that House Bill 2819 could be helpful in maintaining some of these costs. We really believe the only way older people are going to see real relief for prescription drugs is for the federal government to provide an expansion of the Medicare program.

With that being said, we really appreciate your taking the time to look at this issue because I'm sure as we hear calls, your office gets inundated with calls from people who are struggling and trying to manage with these expenses. It's very appreciative.

The only suggestion that we have for making a possible improvement to the Bill is to request that any fines elected under Section 7331b be dedicated to the PACE/PACENET program.

Our last comments we wanted to talk about has to do with the recent publication of the Department of Public Welfare's proposed regulations to eliminate the MA or Medical Assistance nonmoney payment, NMP, spend-down program in Pennsylvania.

The reason I think this is relevant for today's hearing is there is a lot of older adults and really -- it's not just restricted to older adults, but many older adults do use this program. Their incomes are just slightly over the MA limit or over the PACE limit or may not be able to afford PACE copayments. They use this program.

It is a very cumbersome program in that anyone who that is eligible for this program has to come up with your receipts. You have to spend your

income down to what the current MA limit is.

Once you get to that limit, you can have your prescription drugs and other medical expenses covered through MA. So this is really what -- once this is gone and they're currently -- the regulations were just published earlier this month. If this is gone, that safety net is going to be gone for this older group of individuals.

DPW says that over 7,000 people would be impacted by this benefit. We're very concerned about these individuals not having another alternative because this again was a safety net kind of a program.

We would ask that if any support that you could provide to communicate to DPW in opposition to this -- and the regulations are also being reviewed with your colleagues on the Health and Human Services Committee -- you know, if you can express this approval for eliminating this benefit, we would appreciate that.

In conclusion, we support House Bill 2819. Again, we appreciate your holding these hearings today to talk about this issue. Thank you again for allowing me to speak. I'll answer any questions.

CHAIRMAN GANNON: Representative Barrar?

REPRESENTATIVE BARRAR: Thank you, Mr. Chairman. Kathy, on the AARP study, the estimated $480 out-of-pocket expenses, that's a yearly figure?

MS. CUBIT: Yearly figure.

REPRESENTATIVE BARRAR: Roughly $40 per month is being spent. Is that -- what group of seniors did that encompass? Is that seniors nationwide, Pennsylvania seniors?

MS. CUBIT: That particular figure is for the summary study of Pennsylvania. It didn't have a breakdown at least from the summary of the study that I read.

REPRESENTATIVE BARRAR: That would include the insured and the uninsured seniors?

MS. CUBIT: Yes.

REPRESENTATIVE BARRAR: It seemed awful low. That would indicate to me that there really isn't a problem if you were spending $40 a month in total in prescription drugs. I don't really see where there would be a problem there. I know there is because they come into our office. You're identifying PACE/PACENET.

It says 35 percent of older Pennsylvanians and 50 percent of seniors reported spending over

$100 per month in prescription drugs. It's hard to look at that figure because PACE and PACENET are different where you have the $500 spend down with the PACENET program in order to get into it plus a higher deductible. Was that broken down in a study?

MS. CUBIT: That was a different study. That was done by the Commonwealth Foundation and the Kaiser Family Foundation They did do a breakdown for Pennsylvanians. But again, they did not break -- they did not separate PACE and PACENET.

They separated those that were either in one of those two programs or were not. And that's the summary that I provided here. But they did not break it down further.

REPRESENTATIVE BARRAR: And I think the same flaw sits with the next statement about the 8 percent in PACENET that did not fill a prescription. And I really think in future studies, it really needs to break them apart because they are different with the $500 deductible.

I think we realize that the people we need to identify are not the people spending $40 a month on the prescription drugs. It's the guy with the catastrophic problem that is spending.

We have them coming into our office. It's

just devastating for them. And the statistics, if you can ask the Commonwealth Foundation in the future to break that out, really in a sense, it is misleading because I think the PACE program with the $6 deductible, it's really difficult to -- I think it's difficult to spend $100 a month just in copays on that; but PACENET, it's rather easy for at least the first couple months that you would spend that kind of money.

MS. CUBIT: And that $100 was the baseline for the study. They didn't really give how far -- you're raising very good points with these studies. But the most recent figures, I could find and mail them to you.

REPRESENTATIVE BARRAR: But I'm not saying there isn't a problem. There is a problem. We need to address it as quickly as possible. It would be nice to see the federal government to come up. Thank you.

MS. CUBIT: Thank you.

CHAIRMAN GANNON: Do you know whether or not in that study that Representative Barrar just referred to and the average included in that group have no prescription expense whatsoever, it's an average of the total whether they had a meeting

number?

MS. CUBIT: I only saw a summary of that particular study. It did not. That was pretty much -- you know, it went on to explain some of the other problems that people were having; but that was the figure that was quoted in the summary. I did not see that. I could try to refer to --

CHAIRMAN GANNON: That would tell us why half of the senior population is paying what they're paying. That would give us a better benchmark.

MS. CUBIT: Sure.

CHAIRMAN GANNON: I know from the calls I get in my office, predominantly, those folks are paying like this woman you were telling us about. Thank you very much.

MS. CUBIT: Thank you.

CHAIRMAN GANNON: Thanks for sharing that information with us.

MS. CUBIT: Thank you.

CHAIRMAN GANNON: Our next witness is Beth McConnell, state director of Pennsylvania Public Interest Research Group.

MS. McCONNELL: Good morning.

CHAIRMAN GANNON: You may proceed when you are ready.

MS. McCONNELL: Thank you. My name is Beth McConnell. I'm the state director or PennPIRG, Pennsylvania Public Interest Research Group. PennPIRG is a nonprofit, nonpartisan public interest advocacy organization representing about 8,000 citizen members across the state.

PennPIRG works to educate to safeguard consumers, revitalize participation in democratic government, and protect taxpayers.

I would like to thank Chairman Gannon for introducing House Bill 2819 and for holding hearings on the important subject of pharmaceutical pricing in Pennsylvania as well as for inviting us to participate.

I would like to focus my comments today specifically for the reason of rising drug costs, the anti-competitive and anti-consumer practices of the pharmaceutical industry and legislative solutions that can bring in the cost of prescriptions for state government and consumers in Pennsylvania.

As we know, rising prescription drug costs has a significant adverse impact on not only consumers but state government as well. The costs are continuing to skyrocket.

In the year 2001, the average cost of a

prescription in Pennsylvania exceeded $50 which was an increase of 9 percent from the year before. That financial burden is placed on both insured residents and uninsured residents, particularly insured residents can sometimes cause individuals to choose between drugs or food or other necessities.

In fact, again, referencing to the study that Ms. Cubit referenced earlier, about one-quarter of seniors did not fill a prescription or skipped a dose due to high cost of prescription drugs during that year and about 35 percent of those who are uninsured did one of those two things.

That rising cost of prescription drugs not only has a significant impact on the uninsured who have access to medications they need to sustain quality of life, but it also has a significant impact on taxpayers.

State government is dealing with the increasingly shrinking revenue stream yet still needs to provide prescription drug coverage to state employees and retirees. That's the cost of the drug increases, that the strain is going to be felt even greater.

Businesses across the state are also feeling the strain as they are struggling to provide

prescription benefits to their employees. In fact, Aetna reported that employers have seen an increase in drug benefit costs of about 22 1/2 percent in the year 2001.

And then, of course, we're very familiar with the struggles that the PACE and PACENET program are facing right now as the cost of drugs skyrockets and the number of seniors that need the benefits provided by the program grows. The resources to fund that program are remaining stagnant. The program itself is in danger of a collapse unless we find a solution.

In order to discuss solutions to those problems, I think it's first important to look at the pharmaceutical industry's use of their revenue in our consumer dollars, where that money goes in order to discuss appropriate and proper pricing regulations or restrictions.

I would like to focus some comments and talk for a moment about some recent studies into how the pharmaceutical industry is specifically steering consumer dollars more towards profit and marketing and advertising because that's been something I think has been very controversial.

The prescription drug industry does argue

that rising drug prices are needed in order to fund research and development to new groundbreaking drugs. As I mentioned, that's simply not true.

The National Institutes of Health reports that taxpayer-funded scientists conducted 55 percent of the research that led to the discovery and development of the top 5 selling drugs in 1995.

In addition to that, much of the research and development funds that are spent by the pharmaceutical industry are increasing for what are called me-too drugs or copycat drugs. So minor modifications on existing formula Clarinex and Claritin are a perfect example which is allowing the drug industry to market a whole new -- well, actually, a very similar drug that is already out there yet charge brand new prices for it.

In fact, between 1982 and 1991, 53 percent of the new drugs were so-called copycat drugs; and then in the 1990s, as nearly half of the new drugs that were on the market were simply just new combinations of drugs that were already approved.

In addition to that, the pharmaceutical industry already receives enormous tax breaks for research and development from the federal government. In fact, federal law allows for about 34 percent of

tax deductions, tax breaks on research and development by a pharmaceutical company.

The Congressional Research Services said that the pharmaceutical industry is the most likely taxed. What we do see, however, is about 27 percent -- and some estimates are higher than that -- of pharmaceutical revenue is spent on advertising.

Ad spending skyrocketed in the past year, several years, in fact, from approximately 900 million in 1997 to 2.5 billion in 2001. More than a 150 percent increase and another $9.3 billion is estimated to be spent marketing directly to medical professionals such as doctors and nurses and other sorts of medical professionals.

In fact, HHS, Department of Health and Human Services, just recently warned the pharmaceutical industry -- I believe it was about two weeks ago -- that they may be violating federal fraud and abuse laws with some of these marketing practices to the medical professionals.

In addition to that, the pharmaceutical industry continues to engage in anti-competitive practices. There are more than 19 recent class action lawsuits for price exclusion, anti-competitive practices, deceptive marketing, and fraudulent

pricing.

I'm just going to highlight briefly two of these cases that I think are very telling. In one case, Cipro, which is the best-selling antibiotic in the world, Bayer is charged with entering into an agreement with generic companies to keep more affordable versions of Cipro off the market.

Bayer is accused of improperly paying generic companies at least $200 million to not market the generic version of the drug. In fact, the Federal Trade Commission is investigating that allegation right now.

In another case, the manufacturer of Lupron recently settled a case with the federal government for fraudulently selling drugs to doctors below the average wholesale price allowing the doctors to pocket the difference they would charge the higher priced to the Medicare program or to insurers.

That gave the doctors the incentives not to prescribe the cheaper generic Zolodex that was available at that time. In fact, the settlement for $875 million was the largest fraud settlement in history. There are still suits pending on behalf of consumers.

All of this contributes to the fact that

the pharmaceutical industry is the most profitable industry in the world. Fortune Magazine reports that the industry realizes 18 1/2 percent compared to about 4 1/2 percent profit of the average Fortune 500 companies.

As is recognized in House Bill 2819, different consumers are paying varied prices for the same exact drug.

According to the Center for Policy Alternatives whereas an uninsured consumer will pay $100 for a particular drug, Medicaid and HMOs will pay $65, federally qualified health centers will pay $52, which is called the 340B price.

The federal government through the Department of Defense and Veterans Affairs will pay $46. The reason for that is that big purchasers have negotiating power.

They have buying power to be able to encourage lower prices from the manufacturers. The Department of Health and Human Services also recognized these price discrepancies in an April 2000 report where they found that seniors without drug coverage pay the most, often 70 to 100 percent more for a common brand of drug than big purchasers.

In addition to that, the PACE program

doesn't actually achieve the best price. This program achieves discounts of about 17 percent of the average manufacturer or price. I can't make a direct comparison to that, to the specific numbers that I quoted a moment ago; but it does not seem to be nearly as good a deal particularly through the Department of Veterans Affairs and the Department of Defense.

I believe really that the state government can get a better deal not only for state run assistance programs but for consumers who lack prescription drug coverage.

Consumers deserve access to affordable prescription drugs, and the pharmaceutical industry has a responsibility to provide those drugs at a fair price.

However, I don't believe that House Bill 2819 will necessarily achieve those results as written by essentially banning any pricing negotiations or different pricing from the same drugs may impede the ability of safeguarding that for large purchasers including HMOs and businesses to negotiate for a better deal with the manufacturer of a particular drug.

I think, unfortunately, given the

industry's historic behavior, they are not likely to then just offer the best price to all consumers in the federal government but more likely to get rid of discounts and rebates that are achievable now.

PennPIRG would suggest a couple of changes to the proposed legislation. First, we would really like to see strengthening of the PACE and PACENET program by allowing the administrators of the program to seek deeper discounts from the pharmaceutical industry similar or better to what the federal government is able to get under the 44OB price.

Second, we would really like to see the pull and negotiating power of all state pharmaceutical pricing, for example, State employees, retirees, the PACE and PACENET program, the prison system.

I think there are a whole set of different state agencies that are negotiating on their own and not necessarily pulling that buying power to demand an even better deal.

In addition to that, we can pass along the discounts that the state government is negotiating with the pharmaceutical company directly to uninsured consumers allowing certain consumers to qualify for the state price if they need a set of income limits

or other types of restrictions that can be discussed.

Then in addition, I think it's important to give the state government the authority to establish brace caps for prescription medication should the pharmaceutical industry fail to negotiate fair prices in good faith after a certain period of time.

Now, other states have passed similar legislation and the state has passed similar law recently.

Unfortunately, PfRMA has filed a lawsuit that has held up the law It has not been implemented. In fact, appeals by PfRMA have been brought before the Supreme Court. The court is considering the case during its current session.

In closing, I just want to remark that, you know, the pharmaceutical industry certainly provides a very valuable service to Pennsylvania by offering drugs and medicines that save lives and improve the quality of life for millions.

In addition, it's important to recognize that the industry does also have a responsibility to shareholders to earn profit. However, the industry also has a responsibility to abide by both the letter and the spirit of our patent laws.

It has an obligation to establish fair

prices for its products since millions rely on them to sustain quality of life. And similarly, state and federal government has a duty to recognize the industry's failure to act in the public interest thus far and take action.

In closing, I would like to applaud Chairman Gannon for his leadership in addressing this issue. I look forward to working with the Representatives and other members of the Committee to discuss it further. I'd be happy to take any questions.

CHAIRMAN GANNON: Thank you very much for that very enlightening and well-documented testimony. I just did a quick calculation. For 7 years, the industry is paying $11.8 billion just in advertising?

MS. McCONNELL: I believe that was one year alone. It's also the difference between advertising and marketing also needs to be separated out. That may be just advertising. Running television and newspaper ads is different than promotions that are given to doctors such as free computers or trips to the Bahamas or those types of things.

The pharmaceutical industry is not required to report details on their marketing expenditures. They're able to keep that information relatively

close at hand so the estimate that I referred to in my testimony, I believe it was $9.3 billion in marketing to medical professionals, is an estimate that was put together by Scott Lovin who is a health consultant. It may be much higher than that.

CHAIRMAN GANNON: Okay. Representative Barrar?

REPRESENTATIVE BARRAR: Thank you. I agree with you. The report is great. There's just one part missing here, the cost and effect that lawsuits have on the pharmaceutical industry.

Do you know what the percentage of what the cost per dollar of profit is that goes out into lawsuits? My understanding, it's about 22 cents of every dollar and profit is spent in defending lawsuits. I know the Fer-Phen lawsuit was 6, 7 billion that laboratories paid out just in the cost of lawsuits.

Does PennPIRG see in there that the limitations on limiting, you know, caps on pain and suffering, noneconomic damages as a solution or a partial solution in this process of helping control the costs of pharmaceuticals?

MS. McCONNELL: That's an interesting question. I guess the first comment I would have is

no, I don't know the specifics on how much the pharmaceutical industry is giving to that.

In terms of what to do to deal with that problem, I think first is assuring that the pharmaceutical industries abide by the letter and spirit of the law. I think that's the first solution.

In terms of whether we should be limiting pain and suffering damages --

REPRESENTATIVE BARRAR: Limiting. Limiting.

MS. McCONNELL: Limiting, sure. As a consumer organization that is looking out in the interest of an average Pennsylvanian or an average consumer, I would actually much prefer that we not limit the ability of the consumer to seek to address the wronged. I would want to see us clamp down on the pharmaceutical industries and some of those practices that are not only unethical but illegal.

REPRESENTATIVE BARRAR: But every drug on the market today goes through the very long process of billions of dollars through the FDA approval. And it's normally a 5-, 6-year, sometimes a 15-year process. It takes a half a billion dollars or a billion dollars to bring that drug to market.

They have done everything that the federal government has required them to do as far as take it to research and the documentation that the drug is safe.

And then unlike in Canada where we always compare our drug prices, the Canadians now have the ability to sue the pharmacies the same way. They aren't limited in their ability to collect on the pharmaceutical companies.

In the United States where it's really a jackpot lottery when you go and sue one of those companies, really, the proof varies from state to state how much of that drug you had to take.

I really think overall, to start bringing down or start controlling the prices, the primary thing we have look at is the cost and the exposure that they're being exposed to in lawsuits.

I think that has a lot to do with the cost of -- high cost of the prescription drugs today.

MS. McCONNELL: I haven't done much research on whether or not the drugs on the market are safe or not safe and that sort of thing. I didn't focus my comments on this today. I'm not prepared to comment on that.

What I would say is it's important to keep

in mind when we're discussing what price is fair to consumers -- something that I mentioned earlier is that the pharmaceutical industry lawsuits and FDA-approval process is still the most profitable industry in the world by and far.

I think that when we are facing a crisis that we are especially here in Pennsylvania for senior citizens as well as other uninsured Pennsylvanians, I think it's not unfair or not inappropriate to request or expect that the pharmaceutical industry offer a fairer price given the leeway and the resources that they have to work with right now.

And you know again, respecting the fact that they have the right to make a profit and a good profit, there's nothing wrong with that necessarily. In that context, I think that's a fair way we could go on getting a better price.

CHAIRMAN GANNON: Representative McNaughton.

REPRESENTATIVE McNAUGHTON: Thank you, Chairman. Thank you very much for your testimony. I apologize for not catching the first part of it, but I caught enough to understand.

I think the pharmaceutical companies that

you reference -- and my learned colleague with the statistics and I disagree on this one -- I think the pharmaceutical companies because of the monopoly that they receive by getting the approval and marketing a drug for 10, 15, or 21 years -- I don't know which one it is -- based on the trademark laws, I think they recoup their profits and cover the cost of possible exposure one hundred fold at least. That's why they're still the most profitable. I don't think the lawsuit aspect is one that should be so much of a concern.

I do have a question concerning your statistics that you listed. The various governmental entities and the purchasing power, is that limited to a specific group of drugs; or is that across-the-board discounts that those organizations receive? Do they find the top 10 or the top 100 drugs that are purchased by participants in their program and discount those, or is this an across-the-board discount that is seen by the purchasing groups?

MS. McCONNELL: That number comes from the Center for Policy Alternatives which is a national organization that drafts legislation, makes proposals to the state legislation across the board.

In terms of how they came up with that number, I didn't read the fine print on the details in terms of how that figured out, whether they did it on a drug-by-drug basis or an average.

I do know that that one that they're using is for the same dosage of one drug, on a particular prescription of an average drug.

I don't know that I can answer your question directly. I can look into it a little bit further and get some more details for you.

REPRESENTATIVE McNAUGHTON: I was just wondering if that would be one way that we could use PACE and PACENET to negotiate and find which drugs are most widely used by that group of individuals and then negotiate a better pricing on those drugs all at the same time making sure we don't have substantial increases in the drugs that don't fall under those qualifications because that's where the profits will be passed on.

Your statistics are fantastic. My brother-in-law is a physician. He travels quite frequently to various wonderful places on behalf of the pharmaceutical industry, and they cover all expenses just to make sure that he understands everything. That is a huge expenditure. Sometimes I

wish I went to medical school. Thank you, Mr. Chairman.

CHAIRMAN GANNON: I would be remiss if I didn't welcome Mark McNaughton who is a member of the Committee.

I don't know what the cost of the litigation -- how that filters down in terms of cost to the consumer. I'm sure that there is some element there, you know, if a drug is manufactured in the United States in one location and then it's sold for less and cheaper in Canada than here in the United States, if there's a cost factor involved with respect to the litigation that should be reflected in the price in Canada also. That would be my thought.

I'm not sure that litigation alone explains why we see this skyrocketing increase in the cost of drugs. One of my observations, too -- and it's just anecdotal from watching TV -- I'm seeing a lot of commercials now that the drug companies are advertising prescription drugs.

The message being that, you know, this particular drug is good for this particular problem. The next time you go to your doctor, ask him to prescribe it for you.

I think it's kind of unique that the

industry is now going directly to the consumer and marketing drugs to the consumer, to go to their doctor and ask for that medication.

My view has always been I just relied upon my physician to prescribe what is best for me based on his diagnosis and what he feels is the best treatment as opposed to me going into his office and recommending to him or her what should be prescribed.

The other thing that I thought was very interesting -- you didn't go into a lot of detail on it -- but it seems from the information that I've obtained that a lot of the costs of developing drugs, even though I would agree that it takes a lengthy period of time, we want to put those safety measures in our drug manufacturing process before they are approved.

But a lot of the research and the development is funded directly by the taxpayer through the grants or the National Institute of Health. Their budget is probably approaching $50 million, and the other side is funded through tax credits for research and development. You talked about the federal tax credits.

I do know that Pennsylvania has a tax credit program which I was the prime sponsor. I

thought it was a good piece of legislation because it encourages them to get into the research and development area which is very critical.

I think we have to lay on the table that these costs are not borne by the company, that they get a benefit from the indirect tax benefit. I think that's what the purpose of this hearing is, to sort things out.

I'm still not clear on the litigation cost, what type of a factor that is because that's probably taken care of by insurance in many instances.

Another question that I don't know the answer to is, Why isn't that reflected broadly across the prescription drugs across the borders? Why does it stop in the United States?

In fact, if it is true, the Canadians -- I did not know that. If the cause of action is a result of the injury of a medication that was improper --

MS. McCONNELL: If I could make two quick comments on that. I think it's also important to remember that the pharmaceutical industry, they have good lawyers. They know what the law is, and they know what the loopholes are in the law. They know the ways to comply and not comply.

Whenever a pharmaceutical industry decides to expand their patent law on a particular pharmaceutical, which is happening consistently and really outrageously lately, they do so knowing exactly what the law is and what they are or are not allowed to do.

However, even by skirting the law, the amount of time that brand-name drug is on the market every single day in some cases illegal, they're reaping enormous profits.

I have some statistics, unfortunately, back in my office. I didn't bring them along with me. In a case AstraZeneca versus Mylor, one particular drug, AstraZeneca, is making millions of dollars every day that case is going to court.

So the money that they're making even after paying out for the lawsuits and just having a couple of months or a few weeks or even just a few days, by keeping that brand name on the market longer may be well within appropriate cost benefit analysis of the pharmaceutical industry or their attorneys.

Then the second kind of comment I wanted to make, I think that encouraging research in development certainly in our own state is a great thing to do in providing tax credits. I think it's a

noble thing and a smart thing to do.

What some states have done, recognizing the challenges that we're dealing with pharmaceutical pricing, is tie in those tax brackets to some public benefit.

A pharmaceutical company will not receive the tax credits outlined in this law unless you offer, you know, a cheaper price to the PACE program. I think there's a whole series of things that you could consider on that.

I know that's something that many other states have pushed forward. I don't know the progress or status.

CHAIRMAN GANNON: I couldn't help thinking on this. It doesn't really have anything to do with drug manufacturing. I don't think any drug company in the United States could do this, but there was a situation a couple of years ago where an automobile manufacturer manufactured an automobile and they placed the fuel tanks in an area where they would explode if there was an impact.

The manufacturer knew this. They knew that these -- but they made a cost benefit analysis, and they felt that to redesign the vehicle to put the gas tank in the right place was more expensive than the

cost they would have to pay for any litigation that would result of any injury or death caused as a result of a tank exploding.

That's been documented. What concerns me very much is if any company was making that kind of a policy decision, you know, in terms of what the cost, additional cost per item would be reflected and it was actually better to go that way than spend the money to design products to make it safer.

That's a documented situation in the automobile industry. They actually obtained a copy of the memo. These are the things that I think we have to consider.

I'm sure irrespective of that specific that when companies design their products, they -- their people tell them there's going to be some litigation. It's purely accidental. There is some good for whatever reason there would be harm.

That's included in the price no matter what. I think it's fair for the company to include that. It shouldn't be excessive. It shouldn't be done deliberately with knowing that there is a flaw in the product.

I'm sure there's no company that is doing that. I think it's a fair question to ask about how

much of that cost should be put in, and it has to be there in order to do business.

I don't think it derives -- it would be the thing that would drive the price of prescription drugs up. Thank you very much --

MS. McCONNELL: Thank you.

CHAIRMAN GANNON: -- for your excellent testimony and taking the time to share that with the Committee.

Our next witness is Mr. Carmen DiCello, director of Government and Public Affairs, Value Drug Company. Welcome.

MR. DiCELLO: Good morning.

CHAIRMAN GANNON: Proceed whenever you are ready.

MR. DiCELLO: I have in front of you my testimony, a little summary. I'm breaking my testimony into four sections. I am going to read part of my testimony, Mr. Chairman.

I try to present to you facts contributed to the high price of medications, the prescription cost proponents, some modifications needed in House Bill 2819, and also some recommendations that I would recommend to reduce the cost of drugs.

As you pointed out, my name is Carmen

DiCello. I'm a registered pharmacist and the owner of two pharmacies located in Pottsville. I currently serve as director of Government and Public Affairs for Value Drug Company, a wholesale purchasing cooperative located in Altoona.

Value Drug Company represents over 1200 licensed independent pharmacists and their employees. As some of you know, I served as executive director of the Pennsylvania Pharmacist Association for over 20 years.

We appreciate the opportunity to provide the pharmacy perspective on House Bill 2819 that would prohibit pharmaceutical price gouging and profiteering.

Chairman Gannon's efforts to address the skyrocketing cost of prescription medication are commendable. Value Drug Company agrees that bold action is critical to relieve this onerous burden.

It is no surprise that our nation, the world's wealthiest, pays the highest price for prescription medication. Why?

Many countries, Canada and Mexico, for example, have formed commissions that negotiate prices with pharmaceutical manufacturers. Consequently, medication prices in those countries

are significantly lower than those paid for the exact same medications in the United States.

The pharmaceutical manufacturers are a very wealthy and, consequently, powerful lobbying force, not only in Washington but also here in Pennsylvania. Two Secretaries of Health and Human Services have refused to implement the medication reimportation legislation passed by Congress and signed by President Clinton.

The US Senate recently passed by a bipartisan vote, 3 to 1 ratio, another version of this bill that would permit reimportation only from Canada. It is currently being considered by the House.

The drugmakers' claim that research and development efforts would be harmed by the implementation of price negotiations loses increasing credibility with each direct to consumer advertiser, television, newspaper, magazines, and even billboards.

There's ample opportunity for price negotiations with an industry whose profit margin in 2000 were nearly four times the average of Fortune 500 companies.

The attached study, Off the Charts: Pay,

Profits, and Spending by Drug Companies, Exhibit A, points out that if meaningful steps are taken to ameliorate fast-growing drug prices and costs, it is the corporate profits, expenditures on marketing, advertising, and administration, and yes, executive compensation that are more likely to be affected, not R&D.

In the Philadelphia Inquirer article, Policing the Healthcare Industry, takes a lot of Boy Scouts, the author, Jeff Gelles, reports the scary climb in our national price tag for prescription drugs which has grown at double-digit rates every year since 1995, according to Families USA.

Those increases include a 19 percent rise in 2000, far outpace the rise in costs for hospital care or physician services, Exhibit B.

It is the pharmaceutical manufacturers who have carte blanche to raise prices at will. Pharmacy providers have no recourse nor does the American public.

It should raise eyebrows and outrage that the price of the 50 most prescribed drugs for older Americans grows on average at almost double the overall rate of inflation in 2000.

This report, Enough to Make You Sick:

Prescription Drug Prices for the Elderly, by Families USA, a consumer advocacy group, was based on data from our own PACE program. See Exhibit C.

You'll note that or the enclosed Merck Human Health Division Price List No. 91A, Exhibit D, the price of our highly prescribed arthritis medication, Vioxx, was raisec 4.5 percent. The very next day, our providers received that increase and throughout the entire country -- in fact, the Philadelphia Inquirer had a beautiful half page ad in color promoting, of course, Vioxx after the 4.5 percent increase.

Pharmaceutical manufacturers also employ discriminatory pricing practices. For an example, community pharmacy providers are denied the ability to purchase medications at the same prices offered to the federal government and to mail-order distributors.

The discounts enjoyed by these entities are not based on volume purchasing but on bogus designations known as classes of trade. Wholesale buying cooperatives and other purchasing alliances offer the same collective buying power from their combined pharmacy provider members but are refused access to most favored prices.

Currently, this discriminatory pricing practice by pharmaceutical manufacturers is in litigation.

Another factor that contributes significantly to high cost of prescription medication is that the drug patent laws contained loopholes that manufacturers have collectively and successfully used to prevent the introduction of generic equivalents to compete with their products.

Such tactics have stalled the market entry of less expensive generics at the end of the branded product 17-year protected period for 30 additional months.

Recognizing the billions of dollars that could be saved, the US Senate again by a bipartisan vote passed an amendment to eliminate these loopholes. That amendment is now being considered by the US House of Representatives.

Finally, one of the most creative ways in which the pharmaceutical manufacturers have contributed to soaring prices is also discussed in Mr. Gelles' article, Exhibit B.

He tells of the four-year investigation by Jim Sheehan, formerly of the US Attorney's Office in Philadelphia, on the connection between drugmakers,

doctors, and a handful of large companies known as pharmacy benefit managers or PBMs which administer prescription plans for insurers and large employees.

Sheehan's concern is that money, everything from small gifts and favors for doctors to multimillion dollar incentives paid by drugmakers to pharmacy benefits managers for putting their products on preferred drug lists can improperly influence the choice of what drugs doctors prescribe. It can also influence drug prices.

It is equally important to understand that pharmacy providers and wholesalers do not contribute to escalating drug prices. We have no influence whatsoever on the prices charged by the manufacturers for their products.

The attached prescription cost components included in the report, Cutting Medicaid Cost without Cutting Pharmacy Reimbursement, Exhibit E, very clearly demonstrates, one, of every dollar spent on medication, 74 percent is paid to the manufacturer. However, more recent data indicates this is closer to 80 percent.

Two, net profit for retail pharmacy average, 2 percent. In my two pharmacies, it's less than 2 percent.

Three, net profit for wholesalers averages only 1 percent. Recent data shows it's 0.72 percent.

By comparison, recent information indicates the median net profit for pharmaceutical manufacturers to be in the 18.5 range.

Payments to pharmacy providers by PBMs and other third parties are not negotiated. Contracts are issued on a take it or leave it basis. In my pharmacies, over 80 percent of our patients have their prescription paid by a third party including PACE and Medicaid.

The payment rates for us have only ever gone in one direction, and that is down. Conversely, prices for the medications we must stock consistently increase as do all our costs of doing business.

Even our Waste Management service was not prohibited from adding fuel surcharges to our invoices when their cost of providing service rose due to an increase in fuel prices. These factors serve to explain the meager 2 percent net profit for pharmacies.

While the purpose of House Bill 2819 is to prohibit pharmaceutical price gouging and profiteering is certainly praiseworthy, there are several issues that do require clarification.

One, the language in the bill never defines price gouging or profiteering.

Two, the bill covers manufacturers, distributors, and retail sellers of drugs if they have five or more stores. Each of these has a unique position in the distribution chain. How can the law apply to each of them?

And three, the bill contains layers of penalties. But only the Commonwealth can sue for damages; neither an injured patient nor a pharmacist could sue under the bill. This clouds the intent and enforceability of the law.

The following recommendations represent an approach to reduce the price of drugs and the subsequent cost of prescription medication. I'm sure the industry's hair is raising right now.

Number one, form a Pennsylvania Drug Cost Commission similar to the Canadian Commission that would allow the Commonwealth to negotiate price discounts with pharmaceutical manufacturers.

In addition, the Commission would oversee proposed price increases to ensure that they are not double the average rate of inflation.

Two, pass legislation that requires drug manufacturers to make most favored prices for the

products available to all purchasers or pass a resolution requesting the US House of Representatives to support the new reimportation bill legislation, Canada only, passed recently by the US Senate.

Ask the President to sign the legislation and the Secretary of Health and Human Services to finally implement it.

Three, pass a resolution requesting the US House of Representatives to support the patent law amendment from the US Senate that eliminates the loopholes that allow the delay into the market a very less expensive generic drugs.

Four, develop a Pennsylvania Drug Formulary with input from a panel of physicians, of practicing medical professionals, incluoing pharmacists, that this disallows the addition of any so-called new medications prior to a one-year evaluation by the panel. Please see Exhibit F, USA Today article, Study: New Drugs not Innovative. This would exclude, of course, any genuinely innovative product.

Five, in publicly funded programs, initiate step therapy protocols. Such protocols have tremendous potential to decrease costs and improve therapeutic outcomes.

For example, use of a less powerful, less

expensive antibiotic to treat certain conditions not only saves money but also reduces the likelihood of antibiotic resistances.

And six, reexamine the General Assembly of Pennsylvania Senate Bill 199, Printer's No. 206, which provides for a single pharmacy benefits manager to administer outpatient services provided through the medical assistance program.

This would return millions of taxpayers' dollars in the form of manufacturers' rebates to the Commonwealth that are lost because they can only be collected in the fee for service programs.

I thank you for your consideration of this testimony. I will be pleased to answer any questions you may have.

By the way, the 22 cents, I would like to see some data on that. That's as bogus as the R&D they're talking about.

CHAIRMAN GANNON: Thank you. We've been joined by Representative Hennessey. Representative McNaughton?

REPRESENTATIVE McNAUGHTON: Thank you. Thank you for your testimony. It's very enlightening. I have a question on one of your recommendations. You say that Pennsylvania should

form a Drug Cost Commission to the Canadian Commission to negotiate the discounts.

Do you know the size of the pull or compared to what Pennsylvania system would be if set up?

MR. DiCELLO: I'm sorry. I missed that question.

REPRESENTATIVE McNAUGHTON: The size of the pull of the Canadian system, the customer base, the dollar value of the drug purchases that currently exist today in Canada as compared to one that would exist in Pennsylvania if Pennsylvania were to establish something.

MR. DiCELLO: It would be very similar, quite frankly. Canada is not as large, of course, as the United States. I have that information, but I don't have it with me. I will get it to you. I don't know the exact size in dollars. Is that what you're asking me?

REPRESENTATIVE McNAUGHTON: Yes. And in addition to that, what is the discount rate received because of the negotiations on the Canadian Commission?

MR. DiCELLO: There are discounts in Canada which, again, the prices I'll drop off in your

office, anywhere from half the price to even three-quarters of the price.

What happens in the United States, we sell at $100 in the United States. They ship it into Canada and sell it for $50, for an example, for the same product. That's why we're asking for the reimportation bill.

If that's the case, we want to take it from Canada and bring it back to the United States and reduce the price.

REPRESENTATIVE McNAUGHTON: I understand. I would be very interested in those statistics.

MR. DiCELLO: What is that?

REPRESENTATIVE McNAUGHTON: I would be very interested in those statistics.

MR. DiCELLO: I'll get them for you.

CHAIRMAN GANNON: Representative Hennessey?

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REPRESENTATIVE HENNESSEY: Thank you. Mr. DiCello. I'm interested in the fourth recommendation, develop a Pennsylvania Drug Formulary with input from the panel. It goes on to say if you want to disallow any new medications prior to a one-year evaluation, can you expand on that a little bit?

It would seem to me if there's a new medication and it is genuinely effective, we should get it into the formulary as soon as possible and not delay it for the year. What is the rationale?

MR. DiCELLO: Actually, I'll show you some data. It's only really about 50 percent of all of the drugs that are introduced every year actually are innovative.

Most of these are copycats and me-toos, a long acting, what have you, much more expensive. So let's get that corrected. The majority of drugs, if you read the article in USA Today, it states that, the study. We have other data to prove that.

All we're saying is if this panel had the authority, if there's a new breakthrough, then this panel would have the authority within 30 to 60 days to put it right there in the formulary. Right now, automatically, new drugs when introduced in the United States or Pennsylvania, it's put in the PACE program. It's put in the Medicaid program. That's it, and no investigation is going on. Is it innovative? Is it cost-effective? Is it better than is on the market right now?

REPRESENTATIVE HENNESSEY: So what you're saying is it not be excluded for a year but new drugs

-- continued to be excluded for a year unless the panel expedites their approval for this?

MR. DiCELLO: There would be a provision in there that would allow it to happen. At the same time, if there is no guarantee that it is a good innovative product and the panel doesn't know, then you couldn't give it -- we have looked at it for a year. It is not an innovative product.

REPRESENTATIVE HENNESSEY: You have some flexibility to allow it to come on earlier. It makes a little more sense. But I'm a little -- if, in fact, there's a lot of copycat drugs out there now, doesn't that argue against the effectiveness against the patent protection that you were talking about earlier?

You're saying that new drugs -- that the pharmaceutical companies are stopping the provision of copycat drugs by extending -- using a loophole to extend after their original time period is gone.

Yet, you tell us there's a lot of copycat drugs out there. What is happening? Is the patent law really as effective as you say it is because you seem to admit that there are already copycat drugs that are already on our list?

MR. DiCELLO: It's very effective. Fifty

years has gone by. We're going to lose it within two years. What are we going to do? Let's put a new innovative product out there. We'll make it a little extra extension time. We'll make it once a day rather than twice a day and so forth like that.

They are prepared. They're no dummies. They're very sharp. They look at that patent. They know when the drug is going off. They have some significant -- sharp lawyers that are right on base with their companies.

They determine ahead of time, we're going to lose this patent within two years. Let's put a new product on there. So what they do is they have two or three years to market that product. At this price -- when the product is on the market at this price and then when the generics come on at this price, then they're in competition. This is up here. That is what is causing the PACE program to be backlogged.

This new quote is a clever way of extending a patent in a very sophisticated way. It's a good way to make money. It's not good for consumers care or producing the cost of what you are trying to do in the PACE program or the Medicaid program to maintain the credibility of keeping our people on those

programs.

REPRESENTATIVE HENNESSEY: Thank you. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Any other questions?

It seems to me that this Canadian Commission is interesting because I had heard in prior testimony at another hearing that the US could go into Canada and get the prescription drug at the Canadian price, and the dilemma I had on hearing that was that the US citizen couldn't be a member of that single-payer system that they have.

I just assumed that there is some way there is a subsidy that the government was paying under that single payer system for a Canadian citizen at the reduced price.

But what you're telling us, if I read you correctly, is that this commission actually negotiates the price across the board. That's what the government pays for the prescription drugs when its citizens -- when it's dispensed to their citizens. But also, that's the price that anybody pays.

MR. DiCELLO: Correct.

CHAIRMAN GANNON: What you're suggesting is that Pennsylvania should have a, rather than this

hodgepodge what we currently have with the Department of Welfare negotiating one thing and the Department of Corrections negotiating something else, some other agency negotiating one of the examples, the retirement benefit program is negotiating that we have one common commission that would negotiate the price for everybody.

That would include individuals who don't have any insurance if they met certain eligibility requirements, that they would get what is now called the state price.

There is no other agency: corrections, welfare, health, whoever, they would pay the same price for that medication. They're also suggesting, as I understand it, that they have a review board look at these innovative drugs and determine whether or not they're innovative or enhancements of drugs that are going to go off patent and will now become generic.

If they were simply enhancements, they would qualify as innovative and automatically go into the program. Is that pretty much --

MR. DiCELLO: Everything you said is correct. In Canada, what happens is they negotiate a price. If you are a drug manufacturer and you want

to use your medication in Canada, the commission determines that through negotiations.

That price is the same price that the pharmacies are charged. That's the way -- that means every PACE that goes in that pharmacy, whether it be a baby or somebody who is 65 or more, would have the same opportunity to get the drug at that price. You're absolutely correct.

One of the reasons my PACE program is going out of existence is because of the so-called innovative products that are going on the market.

The last five years, the new price on the market, it used to be when you got the product on the market, it used to be $25 a prescription. The new ones on the market are $75, $80 on the market.

You can see what is happening with the PACE program every day. It's unfortunate for Medicaid and the private sector, and the PACE as well.

CHAIRMAN GANNON: I'm just being speculative here, but I'm wondering whether or not this price -- big price difference is really a way for a drug manufacturer to urderwrite the loss that they sustained when their drug goes off and becomes a generic that anybody can copy.

In other words, they've got this drug that

they're marketing for what, 15 years? It goes off patent in 17 years. Now, they know that as soon as it goes off patent, there's going to be a lot of competition so that the price pressure will bring that price down.

So now they have a gap. So now they come up with a new innovative version of this drug. That picks up a new patent. But in order to close that gap between the existing now it's a generic or maybe a name brand, it has generic competitors so the price of that has now come down.

They have to make up the difference by charging a very high price for the new innovative drug that fills up that gap. Am I making myself clear?

MR. DiCELLO: Yeah, if you think that's okay. I'm not quite sure --

CHAIRMAN GANNON: I'm not saying --

MR. DiCELLO: I think you're right. There's a method or a scheme to continue. It's been said by the previous speaker. I'll say it myself. They're making 18.5 percent net profit. We have data -- I'll bring that to you guys, too -- from the National Headquarters that within five years, the so-called ARD is taken care of. Then they want to

add 30 more months after that to make it 20 years almost. It goes on.

Then they put these wonder -- some new innovative products -- they extend it even further. It's a money-making scheme. God love them. I have it in the report here. They're spending twice as much in marketing and advertising as they do in R&D.

Look at the net profit from your administrative, your CEO. He's making lots of dollars in his pocket. That's the reason why we're seeing the high cost of drugs. It's not because of something innovative into the market system. It's a method they found to aid them in continuing high margins of profits.

CHAIRMAN GANNON: One last question. If the drug company has a drug and its patent is starting to expire, they start to make some changes to that, does that have to go through the Federal Drug Administration approval process?

MR. DiCELLO: Yes, it does.

CHAIRMAN GANNON: Is that different from when the drug is, you know, totally new?

MR. DiCELLO: If it's even extended, it's much simpler than going through all the research that needs to be done for that particular product. Let's

say the dose is three times a day. Now, the new one is only once a day. There's another application that must go on.

The process is nothing compared to what is was getting the ones that are three doses per day. So yes, there is a process. It's not an overbearing process. You can see it as I pointed out the so-called innovative products, 50 percent of them really only innovative out of the whole scandal.

CHAIRMAN GANNON: Does the FDA in the process of approving a drug or new innovative drug, do they make a determination whether this is really innovative or this is just simply an enhancement?

MR. DiCELLO: Speaking as a pharmacist, we often wonder how the devil they actually allow these products on the market. If it's not going to be cost-effective and not such a good product, there's a method that they're able to do very efficiently.

As I pointed out to you, they're very wealthy and powerful in Washington. They're able to get their expertise people in there and get that product approved. There's no method for looking at cost-effectiveness.

CHAIRMAN GANNON: Representative Barrar?

REPRESENTATIVE BARRAR: Thank you, Carmen,

for your testimony today You have said in the testimony that the last two Secretaries of Health and Human Services have refused to implement the medical reimportation legislation that was passed by Congress and signed?

MR. DiCELLO: Correct.

REPRESENTATIVE BARRAR: Why is that? What is the reasoning behind that?

MR. DiCELLO: Their claim that was marketed very heavily by the drug industry was it was not safe because all of these countries -- in fact, there's more than two countries. There's a number of countries listed.

So therefore, the US Senate -- and by the way, Senator Specter, one of our own citizens in Pennsylvania, supported it. He said, okay. If that's the case, let's get our neighbor in, Canada. They're pretty close to us. They're Americanized as much as any country in the world. Let's allow Canada to get reimportation to come. Let's hope that passes.

It was debated, and it was passed. We're hoping the House of Representatives supports it. It's signed by the President and finally implemented by the Secretary.

REPRESENTATIVE BARRAR: What are they saying is unsafe? That it's the handling of the product once it gets to Canada then reimported -- what is --

MR. DiCELLO: What the drug industry is saying -- God knows what they're saying. It's a safety issue. For some odd reason -- it boggles my mind. Think about this. He just pointed out, and I think you did, too, a patient in Pennsylvania can go to Canada, can go to Mexico and pick the medication up at one-third the price. The United States allows it, and so does the Secretary.

For some reason, I can't -- as a pharmacy professional who has a license can lose my license or a wholesaler who has a license can't do that. You tell me what is wrong with this picture.

It's a bogus excuse not to get reimportation from countries like Canada. That's all it is.

REPRESENTATIVE BARRAR: So it's legal for me to go to Canada and pick up my prescriptions, drive back, and carry them across the border?

MR. DiCELLO: You have to get a Canadian doctor to write it for you. Yes. No one is going to take anything away from you. There are busloads of

-- in Pennsylvania, there was representative -- they had busloads over there. No one was arrested. If I did it, I would be in jail. Same product we're bringing over here. You tell me what the problem is.

REPRESENTATIVE BARRAR: Yes.

MR. DiCELLO: It's not safety. If it is, how dare they allow our American citizens to go over and take the medications and kill themselves?

REPRESENTATIVE BARRAR: Thank you.

CHAIRMAN GANNON: Thank you, Carmen. That was very enlightening and specific to the problem.

MR. DiCELLO: You're welcome.

CHAIRMAN GANNON: I appreciate your coming before the Committee and sharing your information with us.

Our next witness is Mr. Martin Berger, state coordinator of the Penrsylvania Action Council, AFL-CIO.

MR. BERGER: Good morning.

CHAIRMAN GANNON: Good morning. Whenever you're ready, you may begin.

MR. BERGER: I'll be deviating from my testimony. These three folks behind us have done a very good job telling a story. I'm not great on statistics.

I don't know why we haven't had the scandal with the truck companies with Tyco and WorldCom. It's the same kind of a scandal, the same kind of abuse, and same kind of problems.

My name is Martin Berger. I represent the Pennsylvania Alliance for Retired Americans. That is a new organization sponsored by the AFL-CIO. I also represent my union called UNITE. We represent 60,000 united retirees and 250,000 union retirees plus church groups and other groups.

This is the No. 1 issue on the campaign trail. This is the No. 1 issue that we find as we travel around. The groups that I represent are lonely.

My UNITED people form the garment workers. These are the people who made the clothing when we used to make clothing in America. We don't do any of that right now. They are active in our retirees because they're low-income people.

I'm sure the pharmacists can tell you to bring these down to elderly as people come to his pharmacy and fill prescriptions and he gives them the price, that they sometimes are very hesitant.

Sometimes they walk around for a while and go out and come back in again. They don't know how

to handle these kinds of numbers that they hear for 10 pills or 20 pills, 100 or $200. It's a very new kind of thing.

With all of the things that are impacting our seniors today, this is just a burden. This is the straw that broke the camel's back. They can't afford these drugs.

More and more companies are dropping their drug plans. People are being thrown into the market. I do want to comment on some of the things that were mentioned before.

If you watch TV, this is the No. 1 issue. The Democrats will say our plan is better. The Republicans are saying we gave you a plan. How come you don't like it? I can give you four hours on that one, but I won't.

It's the No. 1 issue that we campaign. It is the issue. Iraq isn't the issue. This is the issue. They're going to vote on November the 5th.

Litigation is something that we're doing constantly. My organization is a Plaintiff. I ought to call a lawyer to see what that meant. Right now, Plaintiffs. We're suing the hell out of these people. That's the only way to get to them, the only way to hurt them in some way for the injustice upon

the population of this country.

These are class-action suits by trial lawyers who do not charge us anything unless they collect. I just signed some papers yesterday. We're suing for various reasons.

One, of course, is the frivolous lawsuits that they file, no frivolous lawsuits on the other ends. The other guys use frivolous lawsuits, too, the frivolous lawsuits that they file against a generic drug company to delay as people told you.

If they keep the drug on the market two three days more a week, more a month more, it makes millions and millions of dollars of profit. That's what they do.

Drug profit is like an airline. Did you ever have a fantasy of going on an airline and stopping the plane and giving everybody a piece of paper and saying, what did you pay for this airline, this flight?

If there's 60 people on the plane, you'll get 60 different prices. That's how they operate. They have different prices for different people.

The Alliance for Retired Americans, which is a senior organization, it's an advocate group for seniors. The elderly are being heard. We talk about

50 top drugs, the 50 top drugs that are used by the elderly, you know; and they're the ones who use more drugs than any other sector of our population by nature of the factor that they're aged.

I felt guilty when I went to Canada. I didn't have any prescription. Besides political season, we have got to stay healthy during that time. The 50 top drugs mentioned in the Families USA report, which is one of our correlation allies as is CARIE and PennPIRG and AARP, is that the cost of the living went up in that year 2.8 percent, drugs went up 7.8 percent.

Now, this is a burden upon everybody in our society. State budgets are messed up because of these prices. Union negotiations -- thank God I retired. I don't negotiate contracts anymore because when you negotiate with your employer, it has nothing to do with wages. Wages are never a factor in the current negotiation.

It's the employer cannot afford to give the workers the prescription drugs that they want. The Hershey strike was completely over healthcare costs. The majority of the increase in healthcare costs which are rapidly going up is drugs.

So everybody is suffering from this. It's

not fair. It's not fair that budgets have to be a concerned; that seniors have to be upset; that union workers have to go on strike to maintain their benefits.

In fact, the Hershey strike was settled. That was about healthcare. But these companies make an enormous profit, which has been told to you.

In the Fortune 500 companies, the 500 companies, they're No. 1 They make more profit than General Motors or any other company. Basically, their money -- you think they spend their money. They speak about R&D, as you said. I have friends. I was talking to a guy. I said how come you're not going to come to the picket line tomorrow? We picket PfRMA once a month. We go down to Washington and stand out front and make faces at those people. We did it a few weeks ago, 500 seniors.

He said, I can't come. I said, why? Because my son is a doctor. I have to baby-sit. What do you mean you have to baby-sit? They're taking my son -- the pharmaceutical company is taking my son, the doctor, to New York to a fancy hotel, a nice dinner, and a Broadway show. That's what is going on. That's where they spend their money. That's what they're doing.

There are 535 Legislators in Washington, 435 Congressmen, and 100 Senators. They employ 600 lobbyists. Okay. You can tell they wear the Gucci shoes and fancy everything.

When we come in, we're pretty sloppy and we have a couple of factory ladies. Every profit. You know, they're very generous not to the American public. They're very generous to the CEOs who work for these companies.

In the year 2000, the chairman of Pfizer received a 40,191,485 proffer as a salary and stock options. You know, Kenneth Play and all those people that lost their jobs and went and sat around the dining table and said instead of making 100 million, we're going to making 80 million. What can we do?

While they're lobbying up here in Washington, these Gucci shoe wearers, they want more. They're not satisfied with what they have. They want a lot more.

They want less oversight. They want extension of -- they have legislation to extend patent life. They want to determine who is the chairman of the FDA.

They're going to have an easy time because they have friends in the Legislature. They want less

time for FDA approval. They're not happy with months and months and years.

And yet we -- the government says, we'll take as much time as we have to whether we're doing the right thing or not.

Of course, PACE is the No. 1 program. There's no other state that has a program as good as ours. I do attend a meeting on the Council on Aging. I can't be on the Council on Aging because you have to be approved by the Senate and by the government. I do go to every meeting. I'm recognized, and I sit there and I sit there. They talked about these things.

Now we expect a $93 million deficit in the year 2000 and a $360 million shortfall in 2004, 2005. In other words, it cost a million dollars a day -- a million dollars a day to run a lottery program. There is no other program like it.

The point is -- and to show you how the drug companies have burdened our No. 1 program and every state wants to emulate Pennsylvania is that and these are figures given out in the book that Secretary Broady wrote a recent report on the lottery fund before he left about ideas.

He was determined that we should not have a

higher copay. He was determined that we should have a formulary. He was determined that if -- and his last words were, we may have to drop other programs because the cost of drugs is so high that we may have to drop other programs provided by the lottery such as Shared Ride, tax rebates on your personal property taxes, AAA agencies, and all the programs. That will be the last.

I'm just quoting Secretary Broady because I really admire that man. He said, before we turn the lights out on this department because we can't maintain the lottery fund, that would be the last thing we would go.

It's so very important and so very good. Yet the fact of the matter is -- and I got the numbers there; you don't have to worry about the numbers -- we are serving 50 percent less people; we are paying out more money.

You would think if you were serving less people that we would save you a lot of money, right? But the drug companies with the amazing prices over and over and over again to maintain their profit. Okay.

I took a bus trip to Canada. I took my people. They're a very unhappy group. We kept on

stopping for political meetings. We had one in Philadelphia and Allentown.

Are we ever going to get to Canada? I said, yes. We're going to do other things first that are important. We finally did get to Canada. It was run by one of our coalitions. We didn't do our paperwork like we should have done it.

We got there at 9:00 at night and the Canadian doctors were there waiting for us. They interviewed our people until 1:00 in the morning. They have to write Canadian prescriptions.

To be very honest, there was one prescription that was higher in Canada than the USA. One. I can't remember the drug. We left it there. But the 12 people on this bus who went and got prescriptions from the Canadian doctors saved $4,000, those 12 people alone.

That's $4,000 that is spent in your community. That's money in their pocket that they're going to go to the retail stores and buy the things they have and make contributions to your campaign.

You know, that's what the money is for, not in the hands of the drug companies. Okay. So when you start pushing the legislation here, you're going to be in deep trouble because PfRMA is not going to

sit by and let you get away with anything.

They're going to fight you tooth and nail. They're taking on Maine. Maine has one of the higher bills in the country. It's specifically -- without going into the legal mumbo jumbo from the written -- it says you have to come down to the Canadian price in three years or get the hell out of the straight.

The Governor who was not for it yet, it was passed in the House and passed in the Senate. He's not a D or an R. He reluctantly signed. But when you saw what the drug companies did and how they refused to sell their product, one product in the state, and how they took this to litigation over and over again, this case is now in the Supreme Court.

He really is on our side because these states say, obviously, it will be a long time before the federal government does anything about it until it's a political football.

So we in the states have got to do something about it. Maine is the No. 1 leader; and the Bill got released to Maine, House Bill 44. I've been going around the state making speeches and all of that.

In Michigan, they decided they were going to fight back. There was this plan because under the

law, the drug companies had to give a little recognition to Medicaid and the lower price for Medicaid.

They have a lower price for Cipro when we had the trouble with Anthrax. They had a different price for Medicaid. When some states say we're going to take some people who are not Medicaid eligible and throw them into the prescription portion of Medicaid, not the hospital, not the doctors, but the prescription portion -- as you see, Michigan claimed they're saving $600,000 a day by doing that.

Now, the pharmaceutical company doesn't want that person on the Medicaid. They want that person to go to a retail store and pay the retail price. They don't like that. They're very unhappy about that.

They're suing the State of Michigan. They'll sue you, too. I support 2819. But then again, we have House Bill 1 and House Senate Bill 300 and Tim Murphy's Bill 700 and 300 and 1022 and all of those have done well.

I don't think we're going to be able to pass this session on the Legislature. So I guess they keep going on. So the bus trips were important. I did in my testimony add in the citizen consumer

justice.

These are the savings. Some of them are very high. And PfRMA is going after our people. As far as the doctors are concerned and, you know, they're having a hard time with their malpractice. We're having a candlelight vigil for the doctors next week. Steve, I want you there.

Vermont -- again, Vermont and Maine, Oregon have been the leaders in the fight to represent their people in a proper manner.

And Vermont passed a law just now signed by the government, of course, that if you -- if you're a drug company and you give the doctor more than $25 in benefits, you're in violation of the law.

Recently, an article appeared in the paper, Christmas trees, free tickets to Washington Redskins game with a champagne reception, a family vacation in Hawaii, and lots of cash. These are the things that they give to doctors to promote their products, and that's why the cost is up 15 percent.

In conclusion, this is in this morning's paper in the New York Times, Zocor. I mean do you know what this costs? Do you know how many people in America could get a prescription drug? This cost 15 to $75,000 to put an ad in the New York Times.

That's where they're spending their money.

I think it's very unfair. I think it's very unfair that people who have a problem -- I read my prompts. So you go into the store. You want to buy tuna or whatever the hell this is, tuna or salmon or something like that.

There's dozens and dozens and dozens of different prices in water, out of water, in water, out of water, whatever you want. You have all of the choices you want, or you could not buy it.

You could walk by it and buy a bottle of soda. You got to go in. If you want to go in with this, this says one prescription -- this is for the Legislators. My time is up.

Delaware County, you know how it is. Don't let this Democrat speak. Pass one prescription drug program for seniors and call our constituents in the morning. Okay.

But this is something you don't want. You go see a doctor. He says, you got to take this. I don't want it. You have to take this or else you will be sick. You won't get better. The pain won't go away. You may die.

You have got to take this pill. It's not right, and it's not fair that an industry should have

that power and be able to gouge. I like the title of your bill. I never liked the idea of right-to-work bill, but gouging is right.

We're being gouged by these drug companies. We have to do something about it. I endorse your bill. Thank you, and don't ask any questions.

CHAIRMAN GANNON: Thank you for your testimony. Any questions?

Representative McNaughton?

REPRESENTATIVE McNAUGHTON: I don't have any questions, Mr. Chairman. I thank you for your testimony.

I think that some of the references that were made and the disparaging any comments that were made varying from the pharmaceutical industry to Enron and some others aren't necessarily applicable to today's hearing.

I would suspect that pharmacists should defend their industry. They have every right to. If they do a fine job in doing that, that's the American way and more power to them.

I don't think it's fair to the industry that provides a benefit to society to disparage their CEOs or anyone else who works for those companies or the salaries they make or this is a class envy issue

because that's not what this is.

This is to try to provide a benefit to the citizens of the Commonwealth of Pennsylvania. I think we should keep our focus on that issue and try to refrain from attacking the CEOs and the salaries and the industries and so forth. That's not what this is about.

MR. BERGER: I do that, and I continue to do that. I believe that I think they're taking advantage of our American people. Most of all, they're taking advantage of our seniors.

REPRESENTATIVE McNAUGHTON: Marty, I don't believe that profit is a dirty word. They have every right to make a profit. If they are gouging or doing something improper in obtaining that, that's an issue that this Committee is taking up.

I applaud Representative Gannon for taking the charge and leading the way to this issue. I think it needs to be focused on. Profit is not a dirty word in the United States. That is what free enterprise is about.

If they are a successful industry, I like that especially that they employed them in my legislative district. They're all in the Philadelphia area.

MR. BERGER: They're located mostly in Puerto Rico is where they get tax breaks even more so than America. They move down from America to Puerto Rico.

I really do intend to carry on against these people. I feel very strongly that -- I'm not against profit, Representative. I'm not against profit; but profit made at the expense of citizens, senior citizens, profits made by gouging, that is something that I will continue to fight.

CHAIRMAN GANNON: Thank you. Thank you, Mr. Berger, for that testimory. I'm sorry. Marty, there's a question. Represertative Hennessey has a question.

REPRESENTATIVE HENNESSEY: I am hungry. Can I have the tuna fish?

You mentioned that Michigan had implemented a program that required the crug companies to give deep discounts to the state pharmaceutical programs.

MR. BERGER: It's a federal law.

REPRESENTATIVE HENNESSEY: I'm sorry.

MR. BERGER: It's a federal law. Medicaid is 50/50 in most cases from the federal and 50 percent from the state. There's Medicaid ruling in that. This is what you can charge.

The government already does that. You can charge so much in -- for drugs which they make a profit out of. So Michigan tried to -- and Pennsylvania, they think about moving these people who are not Medicaid eligible but into the Medicaid portion of the prescription part of it and --

REPRESENTATIVE HENNESSEY: You know, your testimony indicated that Michigan had this program and then there was a suit that was filed against the federal government --

MR. BERGER: Federal government.

REPRESENTATIVE HENNESSEY: -- to prevent them from implementing that program.

MR. BERGER: It's a Medicaid waiver, and Medicaid is a federal program.

REPRESENTATIVE HENNESSEY: And how do you understand the action of the federal government just trying to maintain uniformity across the 50 states that they said that Michigan could not do what they were trying to do? What was the rationale that the federal government did or was trying to do?

MR. BERGER: The federal government didn't stop them. The federal government gave them --

REPRESENTATIVE HENNESSEY: It says the Michigan suit was filed against the federal

government. The pharmaceutical didn't?

MR. BERGER: They sued the federal government. The federal government gave Michigan permission to do that kind of a program.

REPRESENTATIVE HENNESSEY: The pharmaceuticals filed this suit?

MR. BERGER: Against the federal government because Medicaid is a federal program. In most states it's 50/50. In most states 51/49, something like that.

REPRESENTATIVE HENNESSEY: Now that's been resolved?

MR. BERGER: It's in litigation.

REPRESENTATIVE HENNESSEY: It's in litigation?

MR. BERGER: Yes.

REPRESENTATIVE HENNESSEY: Is that Michigan program in effect --

MR. BERGER: Yes.

REPRESENTATIVE HENNESSEY: -- or has it been put on hold pending the results of the litigation?

MR. BERGER: The Michigan program is still in effect.

REPRESENTATIVE HENNESSEY: They are getting

the discount?

MR. BERGER: Yeah, but the pharmaceutical company has an injunction.

REPRESENTATIVE HENNESSEY: And they haven't gotten it. Okay. Thank you.

MR. BERGER: Yes. And the main suit has gone to the Supreme Court. They have lost -- as the main bill which is the same as Don Walko's 444, I think it is that bill that went to the Courts. We want some. They want some.

We want won the last one. The highest court approved the bill. It's legal. The Supreme Court has agreed to hear it. We're going to fight. We're going to fight this thing.

REPRESENTATIVE HENNESSEY: Thank you.

CHAIRMAN GANNON: Thank you, Mr. Berger.

Our next witness is Mr. Chris Ward, Ward Advocacy Communications. He's with the Pharmaceutical Research Manufacturers Association. Welcome, Mr. Ward. You may proceed when you are ready, sir.

MR. WARD: Okay. Thank you very much. I do have some handouts with some source material, but I'm not going to follow it precisely.

I prefer to begin a little bit by giving my

background and disclosing my interest and maybe telling you right up front what my bias is in all of this.

First of all, let me begin by stating that I'm a health policy consultant. I live in Ontario, Canada, which is both 40 miles west of Toronto. I spent a number years in the Ontario Legislature in 1984 and 1985. I was government House Leader from 1986 to 1987.

During my time as a Legislator, I introduced items through legislative committees and public hearings. I've been called on over the course of the past three years in my capacity as an independent consultant to testify at legislative hearings in 14 states.

I've also given presentations to organizations such as the International Accommodation of Employee Benefits programs. I actually even do some union groups and do other organizations.

So from time to time, I've been asked to present on prescription drug benefit issues basically because I have an advantage of knowing a fair amount about the Medicaid system ano the health policy of the United States.

And of course, I have a background and am

actively involved in the healthcare system in Canada. It's going to be difficult for me to cover all of the topics that I would like to cover.

So let me begin with my -- by disclosing my bias. Okay. When I was first elected to the Legislature -- it was a long time ago now -- I think I was about 33 years old.

I ran for the political party in Ontario, and my father ran for 41 consecutive years. I was elected fully expecting to serve my time in opposition and enjoy the wonderful advantages only offering criticism and not run anything too construct.

I come from a town of 35,000 people. When the opportunity actually did come that the government did happen to change and I was appointed first as parliamentarian to the Ministry of College which is the No. 2 political position.

To this day, I remembered the new government being briefed and the health communists coming in and telling us that our healthcare system in Ontario which consumes 45 percent of the budget was going to collapse from the shear weight of demographic change.

The aging of the population was going to

bury our problems. It's an issue we dealt with in Canada for a hundred years. Well, that didn't happen.

In my view, the reason that didn't happen was because of innovation, not just prescription drugs, for PHarmco. I would like me to say that but there are innovations of all kinds.

Over the course of the past 30 years, hospitalization rates in the United States and in Canada dropped more than 25 percent.

Innovative medical procedures, I can call my mother who had her gallbladder removed at the medical center when I was a teenager. She was in for a week.

My wife went in to have her gallbladder removed a few years ago. She went in at ten. I picked her up at two. She's either superwoman or there's wonderful innovations in healthcare.

Again, my bias has always been that one of our fundamental challenges is to make sure that we reap the benefits of medical research and development whether it's pharmaceutical research and development or any other kind of medical research and development. That's my first bias.

My second bias is that I truly believe and

was brought up to believe that in terms of our social responsibilities -- and this, I guess, is my ideology -- I really believe that all of us in public service are obliged to keep our eye on the ball to make sure that people because of the range of fixed income should not have to face diaster merely because of their health.

One of the things that struck me as I've been in over 30 states now -- I think it's over more than 40 -- one of the things that strikes me is that we so often take our eye off the ball here.

We start getting innuendo. We start getting into philosophic arguments. I appreciate your questions at the end there, sir, because, you know, this is a not a class struggle. This is about finding solutions for real problems that exist today.

I truly believe that in my country and in your country, one of the things that we need to do is ensure that there is a prescription drug benefit under our respective medicare programs because it is through coverage that you reduce the seniors or affix incomes to person's exposure to health cost.

Just to drag this point home a little further, I can give you an example. I can recall at a public forum a woman getting up and explaining to

the group there that family health cost is around $3500 a month. They had a fixed income of about $5800.

There's no way that that family could cope with that kind of consequence. Now, if they lived in Canada, instead of being $3500 a month, you would pay $2800 a month. Well, I'm sorry. On a fixed income of $5800, that isn't going to help that. That's the fine point that I want to make in terms of that.

Before I go through the slides and some of the details and the data, one thing I want to stress is that prescription drugs are not covered under the main healthcare system through Medicare.

In every state I've been in, this comes as a great revolution to most Americans because they assume that we have a prescription drug benefit on our Medicare program. We have nothing of the sort.

Our Medicare system provides universal coverage, physician service, hospital service under the Canada Health Act. There is no prescription drug benefit under the national Medicare program.

Each and every profit has put in place its own prescription drug benefit system similar to state Medicaid programs with one major exception. I would say that the variety and degree of access and

coverage under preventol prescription drug programs is usually far less. I can give you some examples of that.

I happen to come from a very rich, wealthy province. I did a comparison. I'm really sorry I didn't bring it with me. I will e-mail it or send you the details.

It was nonfunded. I did a comparison of five state Medicaid programs for prescription drugs, two preventol programs. I picked two wealthy provinces in Ontario and British Columbia.

For example, 12.8 of the Ontario population is covered by the Medicare program; approximately 12.8 percent of the Pennsylvania population, is my understanding, is covered by Medicaid.

Our populations are similar. 11.8 million people, 11.5 million people. I think it's a very, very good exercise when politically we're confronted about what about the grass being greener north of that border.

I think sometimes it's far better to have some solid data to look at that that there are fundamental differences in access between different countries just as there are fundamental differences in prices, not on just prescription drugs but on

everything else.

Now, I think I have taken much, much too long on my preamble. I just want to run through a couple of things very, very quickly.

One of the great frustrations from a health policy point of view is when we focus on prescription dugs, we in healthcare, no matter where we're from, whether it's from the United Kingdom, United States, or Canada, we have a tendency to look healthcare in a nice way rather than an integrated way.

We look at prescription drug expenditures which in 2000 according to the Healthcare Financing Administration now, CMS, the US healthcare dollar in 2000 was approximately 9 cents per every dollar for prescription drugs.

So let's be clear. When we talk about rapid growth and that component of healthcare, we talked about a 20 percent increase in spending on prescription drugs. It's 20 percent of 9 percent. So about a 1.8 percent impact on the total.

The only reason I mentioned this was not as an excuse for increase of drug prices. I think we have to be very, very careful of how prescription drugs impact other healthcare expenditures.

If there is one message I would like to

leave with you, it is that, you know, first of all, providing access to prescription drugs from a public policy point of view is noble. From an economic policy point of view, it might be one of the most prudent things you can do in terms of the impact it can have under total Medicaid expenditures.

When you consider, for instance, the 39 percent of the healthcare dollar spent on institutional care on nursing homes -- we even have more detail for you on that breaking up Medicaid in Pennsylvania and 49 other states.

Actually, if you look at the CMS 64 filing that your state did with CMS in 2001, it will show you that the 5.5 percent total increase in Medicaid spending in Pennsylvania last year was .8 percent of prescription drugs.

It's not to say that it's not growing quickly because it is growing faster than other components. Healthcare spending today, tomorrow, ten years from now, and in the foreseeable future will be even more so as your population ages.

Just to go on to that point a little bit, if you'll look at one of the slides there, it looks at the shift of America's population. This is of great interest not just to the state but also to

employers.

You'll see that over the course of the next ten years, the proportion of the population of ages 18 to 24 declined 7 percent while a proportion of the population age 45 to 64 will go up 15 percent; age 65 plus will go up 10 percent.

Now, a lot of people will say, why the heck is that important? Who cares? Let's look at the CDC data for Pennsylvania alone of the prevalence of one chronic condition, diabetes; one in every ten healthcare dollars is spent on diabetes.

It's one of the most costly health services of survival. 35 percent of diabetics have a family income of less than $20,000 a year. Proportionally, diabetics tend to rely more on programs such as Medicaid.

When you consider that in Pennsylvania, for the age 18 to 44 population, 1.7 percent of that population will have diabetes and then that balloons to 7.3 percent in age 45 to 64.

As this shift moves through your system, one of the fundamental challenges you will face is how in the Medicaid program are we going to manage that growth in expenditure?

I think there's plenty of clear evidence to

show that appropriate treatment through innovative medicines can have a fundamertal impact on hospitalization and physiciar visits.

I would urge you to consider anything that you may be considering in terms of how you address enormous budgetary pressures on your prescription drug benefits that you provice now, that you be very, very cautious in terms of what you do from an access point of view because having access on new therapies in the long run will, in fact, help you contain those costs.

There's a way to quantify this. We always hear of the shift of healthcare spending, but spending goes down. Yes, well, when you look at that population chart, health spending will never go down.

If you froze prices just because of the prevalence of a chronic condition changing with the population shift -- but when we consider that, in 1990, 45 percent of all healthcare expenditures in the US were on hospital care. That's dropped to 40.5 percent.

At the same time, pharmaceuticals in the outpatient services have shifted upwards. But if we look at the impact that innovation has had on health resources and health spending, you'll find that the

rate of hospitalization in this period dropped. The average length of hospital stay has dropped 22.5 percent.

Those have a net impact of reducing by over 50 million the number of hospital bed stays annually. This is not accumulative. So that shift in cost from inpatient to prescription drugs and outpatient care results in $100 million annual cost to avoid.

So again, put it into perspective. Obviously, you want to make sure that you're managing your prescription drug costs as effectively as you can. You're getting the price. You're assuring that the patient is getting the right drug.

There's a lot of mechanisms to do that. I would caution you on the two-hour trip. I want to talk about a couple of things that were mentioned by previous speakers before opening up to questions and, you know, again, I'm dating myself a little bit; but we had quite a discussion on the so-called me-too drugs of a prescription drug product.

I'm going to give you an example from my history and your history because back in 1985 when I was in the Legislature, one of the big issues was whether or not we were going to reimburse prescription drug products for reflux disease and

ulcers.

I'll just give you one example. In 1980, there were three million hospital beds used for the treatment of ulcers and reflux disease. Within 10 years, that dropped to 900,000. That says nothing about the surgeons. That in itself represents a hospital voidance.

Most of that was because medical research discovered a whole bunch of things. First of all, there were incremental drugs. It is true that the lowest most possible effect for the treatment for ulcers is good for 70 percent of the population. The incremental improvements got it closer to 100 percent because of improved environment.

When someone gets up here and says most of what of the pharmaceutical industry does is an incremental improvement on the existing drug product, you're absolutely right.

That's stimulates competition. That improves the effect. The fundamental challenge is to make sure that those who benefit from low-cost drugs get low-cost drugs.

Those that need something more get something more. I'll give you the example of my products. It requires an automatic generic

substitution. Virtually, every other person does that.

That's a generic substitution. When you look at programs when they try to make therapy a substitution, that's when you're walking down a minefield. It's going to have a major impact on drug outcomes.

So again, those are my comments on the issue. I guess the other thing that I want to talk about because I find this very frustrating is the whole business of patent life for a prescription drug.

A patent begins when you register with the patent office when you come up with something that you would like to secure because of your brain power. You want to protect your intellect.

If you invent the widget or a fuel cell for a car or whatever, once you're pretty confident that you know that you got a product that you want to protect your research on, you walk into the patent office and your patent goes on for 20 years.

If you're inventing the widget, it might take about a year and a half to get it into market. If you go in with a new drug molecule, on average, it's going to be 11 1/2 years.

That's 11 1/2 from the time of identifying the molecule that you want to pursue, going through lab trials, in vitro trials, animal testing, patient clinical trials. It runs on average 11.5 years.

So now we're talking about a product that has an effective patent life, not a couple years but 9.5 years. That is one area that the pharmaceutical industry area differs fundamentally.

So when the pharmaceutical industry regressively defends its patents, it's because they have a very, very limited window in which they can recover the cost of research development.

Secondly, what is the cost to manufacture a drug product? My experience has been very, very little. What the cost is, it costs $802 million in research and development costs to bring a new drug to market.

Only three out of ten drug products that are marketed in the world today recover the cost of research and involvement plus the cost that aren't recovered on the other side plus the cost of research failure and successes. I wanted to try to that one.

Secondly, we've heard lots of innuendo about who spends what in terms of research and development and everything else. The data is clear.

You got Ernst & Young and independent organizations that look at this.

In the United States, a $30 billion damage is spent by the pharmaceutical industry on research and development. It's true that they spend a lot of it. It's applied research that actually brings about the product.

So it is clearly a joint exercise. I want to compare that which is 10 percent of the size of my country. The pharmaceutical industry will spend 16 million, 1/50th of the 30 billion that is spent here.

That's made up quite a bit by the government who spends another 400 million compared to 16 billion. I want to stress that, indeed, you do lead the world of pharmaceutical research and development.

You're the first to benefit from the products. You have better access than everybody else. You have the marvelous research and development infrastructure.

Now, some people may say that's not fair because the prices are higher. I want to point out to you that according to the Organization of Economic Development, which is a nonprofit public agency, that on a per capita basis, Americans spend 35 percent

more than Canadians for prescription drugs, 35 to 40 percent more.

On a per capita basis, Americans pay about 250 percent or more for physician services and about 200 percent more for hospital services. Surely, if the value of a prescription drug is partially what it can replace on other healthcare expenditures, then I think we really need to keep that in context.

There's a lot more that I would like to say about Canadian prices. I'm sure you have a lot of questions. It might be better if we handle those questions rather than for me to go on. Thank you.

CHAIRMAN GANNON: Thank you very much, Mr. Ward. Representative Hennessey?

REPRESENTATIVE HENNESSEY: Mr. Ward, let me just go back to one of the charts in the back of your -- well, it's actually on page 11. The indication is that the Canadians, despite the fact that we hear today that the drug prices for the same pill or pills are considerably smaller, you're saying that 15 percent of the --

MR. WARD: Health oollars.

REPRESENTATIVE HENNESSEY: -- healthcare costs that an individual pays goes to prescription drugs in Canada and 12 percent in the United States.

That's driven by the fact that you spend more for treatment in general?

MR. WARD: Absolutely. Let me put that --

REPRESENTATIVE HENNESSEY: Quite frankly, I'm thinking if we know you can go to Canada and save money, to say that we spend a larger percentage really is a situation where finding, you know, there's analyses and statistics and you make the statistic say anything you want. Give us a clearer picture on that.

MR. WARD: I want to put this into context. This is not mine. This is the OECD. Every year they publish health data on all of the countries. It's kind of like the bigger body. It incorporates the 29 most developed countries in the world.

What this slide does is it looks at the percentage of total healthcare spending in each country by each of the components of healthcare. Americans, among most developed countries in the world, spend the lowest proportion of the healthcare dollar on prescription drugs, far less than Canadians do, much less than France, and half of what Italians do.

Now that -- it's very, very important you rightly stress that. That doesn't mean prescription

drug prices in America are low. You have the highest prescription drug prices in the world. That is also a fact.

What that means is that your healthcare costs are far and away higher than any other country in the world. If you go back to the chart where we broke out the physician services, hospital services, prescription drug services, you can see what it would represent would be smaller than the percentage of prescription drug costs because you spend much, much higher for other services.

That is merely -- to drive home the point is I can't tell you, you know, what someone should be paying for prescription drugs. I can tell you that we spend more of our healthcare dollars on prescription drugs than you do. That's the bottom line.

REPRESENTATIVE HENNESSEY: If the same medicine is sold in Canada for $20 and bought here in the states for $120, you know, say it's an Merck product, is the $20 sufficient for Merck to make a profit selling it in Canada? If not, why would they simply refuse to ship it in Canada?

MR. WARD: That's a very good question. If the product were sold for $20 per prescription

throughout the world, they cannot afford to sell that product.

Pharmaceutical companies do not have a choice whether or not they can launch a prescription drug product in any country. Canada, like most countries, not all but most countries, is quite different in terms of the laws regarding healthcare and including prescription drugs.

Let me first focus on prescription drugs, and then I'll switch to healthcare generally. In Canada, a pharmaceutical company has to go to a federal government agency to the patent and review board before it launches a product. The review board determines what the price will be. It is not a free market.

That is generally set if it's a new product for which there is no other product in that category. It is usually set at the average price of that product in other countries.

If it's a product for which other therapies are available and are eligible, we set that price no higher than existing therapies.

First of all, Merck does not have a choice in terms of whether they can launch the product. It has to launch that product. The reason it has to --

REPRESENTATIVE HENNESSEY: Hang on a second. The panel sets the price of $20. Does Merck have the opportunity to say we don't want to ship it to Canada?

MR. WARD: Absolutely not. I'll tell you why. Under international patent law, anybody that gets a patent has to work that patent. That's a fundamental tent of international patent law.

For instance, if you patent a widget in the United States and in Canada and you don't want to sell the widget because you don't think anyone is going to by a widget, if you don't utilize that patent, then another company can come along and manufacture that and basically abscond with your patent protection.

So the mechanism that prevents a company from refusing to launch a system that existed in Canada --

REPRESENTATIVE HENNESSEY: Hang on a second. Does Merck have any ability to restrict that drug into Canada?

I think what I hear you saying is if you're going to have this patent protection, you have to provide the medicine in Canada.

MR. WARD: That's right. Or --

REPRESENTATIVE HENNESSEY: Do I have the ability to say, we'll ship 20 percent of what they're asking for in Canada?

MR. WARD: It wouldn't do you any good because what would happen is another company, a generic company would then have the right to manufacturer that product and ignore your patent protection. They would market it for the $20. You would lose your patent.

REPRESENTATIVE HENNESSEY: So you're saying that I lose my patent even if I do ship in -- if I don't ship in the quantity that is satisfactory to this panel?

MR. WARD: This is a case -- I think we're almost getting -- maybe we're drilling a little too deep. Let me go back and try to --

REPRESENTATIVE HENNESSEY: I'm just trying to understand how your system works because --

MR. WARD: No. I hear what you're saying. A pharmaceutical company does not get to choose the price they want. That's set by government legislation. That's Item No. 1.

Item No. 2, if a company does not choose to launch a product in Canada, they can then lose its patent to a generic product under a compulsory

license. You can appreciate it as a big deal.

If it cost 6 cents to manufacture it, you can probably sell it for less than $20. That's Point No. 2.

The companies really do not have a choice. I'm going to qualify this. They don't have a choice in whether or not they can launch in Canada. They sure as heck have a choice as to when they launch in Canada.

This is where it gets very interesting. Okay. Of 31 drugs that were launched worldwide in the year 2000, as of last week, 8 them were being sold in Canada.

So 2 years later, only 8 out of 31 have ever been launched there. The truth is -- I'll give you an example.

REPRESENTATIVE HENNESSEY: These other companies lost 23 different patents.

MR. WARD: No, no. They still have them. They will launch eventually.

REPRESENTATIVE HENNESSEY: But in the meantime, what is protecting their patent? If they haven't launched, why isn't some other company knocking off the product and launching it themselves?

MR. WARD: They are in the process of

launch. They are not refusing to launch. They will launch two or three years down the line. Okay. Because, first of all, they'll make it available in markets. I'll give you an example --

REPRESENTATIVE HENNESSEY: Because I guess the problem that I'm having with that is that you're saying they can play this out, play the game, play the system, and not launch but say they're going to launch.

Five minutes ago, you said if they don't launch, they're going to lose their protection.

MR. WARD: That's right.

REPRESENTATIVE HENNESSEY: Did they lose it or not lose it?

MR. WARD: Representative, what I'm telling you is they will launch. They will launch, or they will lose their patent. When will they launch? At the last possible moment

REPRESENTATIVE HENNESSEY: Okay.

MR. WARD: Okay.

REPRESENTATIVE HENNESSEY: And that last possible moment may be five, six, seven years down the road?

MR. WARD: I think they will step in before then. I'll give you an example using the asthma

drug. It was researched as one of the blockbuster products in the last eight years that was actually researched and developed in Canada for America. It was launched in Canada.

Canada was the 29th country that America launched that product. It's the last place because they have to launch into markets where they can recover. They want a free right. They get a great benefit. They get low prescription drugs.

We were talking earlier about bus trips. I took a busload of patients without any pharmaceutical industry funding to the Eastern Maine Medical Center to get services and products for healthcare that weren't available in Canada.

I had a guy who needed an MRI. He could have it but had to wait nine months. I took four people in to get prescriptions drugs that weren't available in Canada.

They went in for CAT scans, for specialist consultations. It is illegal to purchase an insured service. There's only three countries in the world you can't purchase if you're a doctor, you can't purchase a service.

My doctor said I needed a CAT scan. It took me eight months. I could have gone to Buffalo

and paid $200. 166,000 Canadians did that last year. We have a price control healthcare system.

There's a benefit to that. Benefit No. 1 is we have an equitable universal system. Nobody gets the same level of service which appeals to a certain ideology that everybody gets the same. That's No. 1.

Number 2, we have a rational healthcare system which means if you have breast cancer and need radiation, you won't wait 60 to 90 days before you can start that therapy.

But guess what? Ycu're going to wait poor or rich. If you have a prescription drug benefit, first of all, they're only going to cover -- they only cover 24 of the top 400 drugs sold in Pennsylvania under the Medicaid program.

They usually don't cover them until after they've been on the market for two or three years. Plus, a senior from America can hop a bus, go into Ontario, go to a drugstore, get a prescription drug that is two or three years old, Zocor or whatever, at a price that is cheaper that is government controlled.

I'll tell you that drug wouldn't exist if the people that discovered, researched, and

manufactured that drug couldn't make a profit somewhere. Lord knows it isn't in Canada. There's a balance to this.

REPRESENTATIVE HENNESSEY: Did I understand you earlier when you said you were the majority leader --

MR. WARD: What's that?

REPRESENTATIVE HENNESSEY: Didn't you say when you were the majority leader up there, you authored that policy?

MR. WARD: No. I got to tell you --

REPRESENTATIVE HENNESSEY: Or throw feet to the fire?

MR. WARD: I got to tell you, when we introduced -- this is interesting and particularly with the gentleman from the AFL-CIO here. When we introduced the program, we covered virtually every prescription drug. This was back in 1985.

The program only cost like 150 to $200 million. Now it is limited to low-income families. Today, all seniors, even high-income seniors, which is probably a really bad idea because now it's costing $2 billion a year.

It's not just targeted. It's kind of a blanket benefit that people that get elected that

decided that it would be good to give everybody coverage.

If you made a million dollars a year, you still get free drugs in Ontario. The difference is, back in 1985, virtually every drug was on the formulary.

In Pennsylvania, Medicaid under Medicaid law, every drug that is on the national formulary supposedly is on the Medicaid formulary. So virtually, everything that is available is available through Medicaid. Not anymore in Ontario.

Of the 148 drugs that were approved for use in Canada from 1991 to 1998, only 18 of them are on the formulary as of January 1st, 2000.

So basically, what they do is to save money, they only cover generic drugs, older drugs and they restrict access. Now, my point on that was back in 1985, virtually every payer would be on the formulary for their members, for their employees.

It's a trusty plan for your union members. I can tell you today that there's not an employer in Ontario, there's not a urion in Ontario, not the United Steel Workers of America or whatever, not a single union has the formulary for its members because they get turfed out on their butts if they

try to force that kind of restrictive with their limitations on its members.

They all go out and purchase private drug plan coverage based on much more open formularies -- let's face it. If you're an employer -- and I don't care where you are, if you're an employer, 40 percent of your health and disability, short-term disability; 15 percent is long-term disability; 28 percent is for medical cost.

You know, it may seem really bad that your drug costs are going up every year making those prescription drugs available and the impact that they have on reduced long-term and short-term disabilities. Those are choices a private sector can make.

REPRESENTATIVE HENNESSEY: Thank you.

CHAIRMAN GANNON: Representative McNaughton?

REPRESENTATIVE McNAUGHTON: Thank you. Mr. Chairman. There's been so many facts and figures thrown around here. They're confusing.

I think we should just focus, if we can, on the prescription drug component and not muddy the water in bringing institutionalized care and everything else.

Frankly, we were trying to focus on prescription drugs. I understand your point. But the focus is that 20 percent increase that the prescription drug industry does every year on prescription drugs, now, you're trying to equate that on 1.8 percent. It's only 9 cents on the dollar. It's still a 20 percent increase no matter how you slice it, is it not?

MR. WARD: It's a 20 percent increase in expenditure, not on prices. I want to be clear on that because let's put it into context.

Most of the increase in prescription drug spending is being driven by increased utilization which is driven by an aging population. You saw that chart on the problems in diabetes in Pennsylvania through that age cohort. That's No. 1.

Number 2, new products that are available this year that weren't available last year add to that component. Price adds to that component.

But in no circumstances do price increases equate on average to anywhere near the 7 or 9 percent that we talked about earlier.

We're talking about the average price in Pennsylvania. We're not looking at the average price. There's different dosages, different

products, quite frankly.

REPRESENTATIVE McNAUGHTON: We're still talking about a 20 percent increase.

MR. WARD: In spending.

REPRESENTATIVE McNAUGHTON: I understand that. Now, 85 percent of the products that come to market are copycat products.

MR. WARD: I would say, no, sir.

REPRESENTATIVE McNAUGHTON: That's statistics that's been given here. Do you have statistics to show us that that's not correct?

MR. WARD: Absolutely.

REPRESENTATIVE McNAUGHTON: That's not part of your report here.

MR. WARD: I will be very happy to send that.

REPRESENTATIVE McNAUGHTON: If that figure is correct and 85 percent of copycats are not innovative, my question is then, where is the cost that you justify these substantial increases? Where is that coming from other than the increase that you're advertising with?

MR. WARD: Let me go back a little. First of all, to me, it's almost inconquest that anybody could come to the conclusion that increased

advertising is driving increased prescription drug expenditures if you look at data on the prevalence and incidence of chronic conditions.

Those numbers don't lie. You can quickly, very easily calculate how many more diabetes patients you'll have in Pennsylvania next year and how many more hypertension patients just using age and risk factor.

So you can quantify that. That increase is absolutely significant. Secondly, the notion that 85 percent of the drugs -- even the FDA, you know, there is a different mechanism for approving a generic drug and improving an innovative drug.

There is absolutely no way on this earth that there's an approach of 85 percent. There are drugs that are classified because of incremental improvements.

I'll give you an example. The Coxton inhibitors, that might not be the best because it's more current; but the Vioxx and the Celebrex, you know, they came on the market about the same time as third and fourth and fifth generation. That has the impact of the competition and actually lowering the prices.

Those aren't copycat drugs. Quite frankly,

they couldn't be patented if they were copycat drugs. They have to be different. So there's differences in probability. There's differences in efficacy.

Basically, the number of people who can tolerate it and also differences in the safety aspect, these aren't bad things.

REPRESENTATIVE McNAUGHTON: I'm not questioning the fact that you come out with new products. I'm questioning the fact that they are brought to the market and are not new products.

MR. WARD: And I'm --

REPRESENTATIVE McNAUGHTON: The question that I had is, Where is this increased expenditure or increased cost? Why is it being masked so dramatically when 85 percent of the products aren't, quote, unquote, new? That's my first question.

And then my second question would be is $30 billion that are being spent, how much of that is being recouped by the pharmaceutical industry through tax incentives, through other reimbursement formulas that are in place for these pharmaceutical companies to do the R&D? I want to know how much of that 30 billion comes back.

MR. WARD: Well, I would assume that all the 30 billion comes back from the products that they

manufacture. It has to come back. Sometimes they get confused because at one point in the day, I can turn on the television and I can hear about Kenneth Play and Enron and Arthur Andersen and ain't it awful how all of these companies are going bankrupt.

An hour later, I can turn it on and, my God, we've got pharmaceutical companies making money. What is wrong with this country? It gets a little confusing.

I have got to say the pharmaceutical industry is more profitable than many other industries in this country. That's being clearly documented.

Secondly, I will say this: The pharmaceutical industry spends $30 million on research and development. If you ask me, do they recoup that in the sale of their products? I would say I would hope so, not only because of what that means in terms of future research and development but also what that means in terms of someone's 401K or to the shareholders.

REPRESENTATIVE McNAUGHTON: I appreciate the response. The question I had though was, Does it not come back in tax breaks and other incentives, not through the sale of the profit?

I appreciate what you just said, but how much of that 30 billion do you recoup up-front or through tax breaks as not part of the sale --

MR. WARD: Well, if there's money being recouped in terms of tax breaks, and that's the issue a policymaker should address. I really do.

I think there might be some states, for instance, that encourage the relocation of industry. And from a national government point of view, there might be some priorities that the collective listing of those elective determinations should provide an incentive in some form.

I'll give all an example. There's 44,000 people employed in the pharmaceutical industry in America. There are 21,000 employed by the pharmaceutical companies in Canada.

There's a big, big difference in terms of the environment that encourages the location of that industry.

REPRESENTATIVE McNAUGHTON: Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative McNaughton.

Just a couple of observations. I spent some time in Canada looking at their healthcare

system. It's a little bit like comparing apples with oranges because of per capita cost. This is called Ministry of Health.

MR. WARD: Well, Ministry of Health on the preventol level.

CHAIRMAN GANNON: The Ministry of Health would negotiate with the physicians.

MR. WARD: Absolutely.

CHAIRMAN GANNON: It's a big book they put out. In the hospital, they pay a lump sum of money annually. It doesn't matter whether they have one patient or thousands of patients. They have to figure out how they're going to take that cost.

When I was up there, there was a little bit of a scandal because the Speaker of the House was getting a cardiac care center located in his town. When you talk about everything is equitably distributed whether or not that was medically necessary or politically motivated, on the prescription drug side, I hear what you're saying.

But it doesn't connect that simply because they look -- they take the ten countries and take the average price of those ten countries, and that's what they say -- that's what we're going to let you charge in the Canadian marketplace for your drug.

With that average, I'm assuming that the low end of making somebody money and at the high end making more money, if you look at that average, the drug company is selling that at a loss.

It's making some profit, maybe not the same amount of profit as the cops with the higher end, as much as the companies with the lower end.

I think it's something we have to look into a little further. It does seem worthwhile to look into that. I know what I wanted to ask. Take a step back.

You use the term compulsory license. In other words, you don't want the patent. You would be able to get a compulsory license from the manufacturer?

MR. WARD: I believe that's in every country, by the way.

CHAIRMAN GANNON: My question is -- and I don't know the answer to this -- is that even though it's a compulsory license, is the cost of that license set by the government or is that something you would negotiate with the manufacturer of the -- you know, the person who holds the patent?

MR. WARD: Well, if we sort of go back to the '60s when basically the pharmaceutical industry

moved right out of Canada and virtually everything was done with a compulsory license, certainly, there would be some negotiations' process.

I think we got to be clear. I don't want to complicate the situation even further because the Patent Medicine Review Board only sets prices for innovative patent drugs which is why generic prices in Canada are -- the top 4 generic drugs in the world on average are 44 percent higher than they are in the United States.

CHAIRMAN GANNON: My next observation would be this --

REPRESENTATIVE HENNESSEY: Do they take buses down here?

CHAIRMAN GANNON: If I'm a drug manufacturer in the United States and say, look, I'm not going to work my patent. Then I go to the subsidiary area in Canada or some corporation; I open it up, and they let you get the compulsory license. So now it becomes generic in Canada. I can now market it at a higher price because I've skirted this compulsory --

MR. WARD: Actually, it doesn't become generic just because of the compulsory license. It would still be subject to patent. It hasn't

happened, which is interesting.

CHAIRMAN GANNON: I just thought of it. Trademark.

MR. WARD: No disrespect, but I'm sure somebody has thought of that, too. And the reason that it hasn't happened, quite frankly, is because -- lots of reasons.

You know, first of all, no company is going to risk losing their product under the compulsory license. One of the interesting things about patent law in Canada, which is actually challenged by the US freight representative, successfully, by the way, is that there was a provision. The industry in Canada is a generic industry. It supplies most of the world.

It's not very large because it's all manufactured. There's very little research and development. Basically, Canadian law used to allow you to manufacture and warehouse any patented drug and leave it on the shelf in Canada.

So for instance, the day that the patent expired in Germany let's say for a product, the following day, that product would show up in drugstores in Germany shipped from Canada because the patent had been copied, manufactured, and stockpiled,

just merely not marketed until the day it expired.

So the whole issue of losing a product in Canada through a compulsory license is not just an implication.

The second point I want to make, well, a lot of people say -- you know, the equitable way to do this is to calculate the prices from the two companies and work up an average.

Well, you know, if it's $80 in the US and $20 in Canada, the average is $50. The US markets 50 percent of the world market. Canada is 1.8 percent of the world market.

So you know, maybe that average price is like around $78. And what would happen is prices in Canada would go up, prices in the United States would come down marginally, and you would generate the same amount of revenue.

One of the biggest stresses in our country today is the fact that they are getting increasingly concerned about that. The Canadians are improving. It's bad healthcare to people that they have never seen in their healthcare provider.

Now, nobody is doing anything about this; and no one really wants to because we're talking about, you know, a small group that come up on buses

and buy prescription drugs for personal use.

Once this is becomes commercialized and institutionalized, both companies are being set up now to ship products south of the border. Quite frankly, that won't be stopped by American legislation. That will be stopped by Canadian legislation.

Canadian law says that prescription drug prices that are set by the government in Canada, the prices to be charged by Canadian consumers does not let you export if you're a manufacturer into the United States.

Canadian law says that you have to certify that product that is manufactured as Canadian consumption. That's one thing Congress would have a heck of a thing doing.

CHAIRMAN GANNON: Can a Canadian -- do they permit mail-order prescriptions?

MR. WARD: Again, this has become the big issue. There are a lot of companies set up for mail-order prescription. Again, each province sets a regulations for the standard of health professionals that they have to follow.

In Canada, a pharmacist is a health professional and a physician is a health

professional. The health profession in every province basically says, you should not dispense a product to a patient that you know nothing about and if you are a physician, you should not cosign a prescription for a patient that you haven't seen.

If that were the case, we could save a whole heck of a lot of money and just, you know, sell directly to patients. I don't think that's where we are going to go because this is about healthcare.

CHAIRMAN GANNON: Thank you very much, Mr. Ward. I'm sorry. Representative Hennessey has a problem.

REPRESENTATIVE HENNESSEY: Chris, can you give us an idea -- I didn't see it in any of the slides here -- any clear-cut indications what the industry spends for research and development as a percentage of its overall --

MR. WARD: Absolutely.

REPRESENTATIVE HENNESSEY: Is that in here?

MR. WARD: It's not in here. I can send it to you. I can give it to you fairly accurately off the top of my head; but I'll also send you the details. The pharmaceutical industry spends on average between 15 and 20 percent of its revenues on research and development. It's twice as high as the

consumer software industry.

As a matter of fact, there's no other industry in the world that has a higher sale. That has been documented not by the industry but by economists. We can give you the data. We'll send it to you tomorrow.

REPRESENTATIVE HENNESSEY: Of the 15 and 20 percent, can you send me data as to how much goes for research?

MR. WARD: Yes.

REPRESENTATIVE HENNESSEY: How much goes for salaries, for the researchers that are there.

MR. WARD: Yeah.

REPRESENTATIVE HENNESSEY: And the question I'm getting at is: How much goes for advertising? How much goes for the wining and dining of doctors and physicians?

You're shaking your head. There's a percentage of that goes -- if it's a minor percent --

MR. WARD: Let me -- the money that they spend on R&D is not the money they're spending on advertising. When I was talking about 15 to 20 percent, that's not just R&D. There was all kinds of data --

REPRESENTATIVE HENNESSEY: I was assuming

development was part of the market.

MR. WARD: No, no, no, no. These are totally different. When somebody gets up here and says, the industry spends $30 million, that is absolutely false.

As a matter of fact -- and most of us -- and this is a study. There were studies mentioned. The most current study that I have ever seen was an international crew that documents all marketing activities virtually throughout the world.

There are few basically as the industry lingers on the healthcare market. They did an analysis of marketing expenditures in the United States for the -- the most current. I think it was for the end -- it was up until July of 2001.

Now, the figure I heard earlier was 9.3 billion. That might be for the end of 2001; but for the end of 2000, the number was 8 billion. If we break down the 8 billion in marketing, it gets very distressing when I hear numbers deliberately misrepresented.

If you take that 8 billion -- I'm sorry -- 16 billion in marketing, 50 percent of all marketing expenditures is for free samples. Free samples are trial prescriptions. They're given by doctors.

Nobody is charged for it

Generally, it's a test prescription. A lot of times, the doctor will sample because the doctor doesn't want the person to spend the money on that product if the darn thing isn't going to work. Not every drug works for everybody.

So marketing expenoitures include samples, 50 percent of which are -- 50 percent of which are for free samples. Of the remaining 50 percent, 25 percent is detailing the hospitals and physicians going to their offices.

I spoke -- that includes the free meals and everything else. It would be listed as detailing to physicians.

REPRESENTATIVE HENNESSEY: Are you saying detailing?

MR. WARD: Yes.

REPRESENTATIVE HENNESSEY: So --

MR. WARD: Explain to them how tne product works, what the potential side effects are, drug-to-drug interactions.

REPRESENTATIVE HENNESSEY: And a large portion of that is the sales rep actually making the call.

MR. WARD: Absolutely. The next component

was about 2 billion annually in advertising. Those are the Wall Street Journal ads, the CNN ads, or whatever.

A hugely large component would be advertising in the Medical Journal which tends to be different because it's not consumer advertising. It generally is the people that read that want to know about drug-to-drug interactions and how the medication works.

The data is readily available. The largest proportion of pharmaceutical marketing expenditures to this day, it represents more than 50 percent for the samples that are given to physicians that are then given to patients.

REPRESENTATIVE HENNESSEY: Thank you.

CHAIRMAN GANNON: Thank you very much, Mr. Ward, for appearing before the hearing.

MR. WARD: I'll send you those other details that the folks asked for.

CHAIRMAN GANNON: If you would send helpful information -- if you send it to my office, I'll issue that other the Committee members get copies of it.

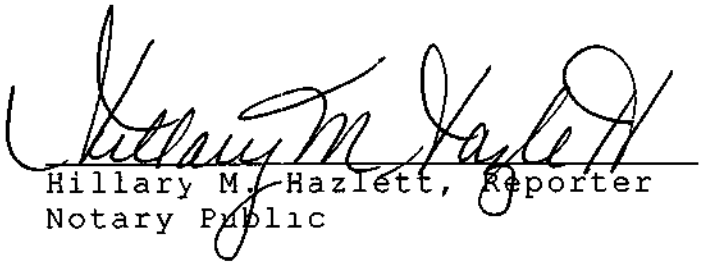
MR. WARD: Thank you.

CHAIRMAN GANNON: There's no other

business. These hearings are adjourned.

(The hearing concluded at 11:47 a.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the within proceedings and that this is a correct transcript of the same.



Hillary M. Hazlett, Reporter
Notary Public