COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

INSURANCE COMMITTEE
PUBLIC HEARING

STATE CAPITOL
HARRISBURG, PA

MAIN CAPITOL BUILDING
ROOM 140

WEDNESDAY, FEBRUARY 8, 2017
9:00 A.M.

PRESENTATION ON
HOUSE BILL 161
PRESCRIPTION DRUG TRANSPARENCY

BEFORE:
HONORABLE TINA PICKETT, MAJORITY CHAIRWOMAN
HONORABLE LYNDA CULVER
HONORABLE GARY DAY
HONORABLE HAL ENGLISH
HONORABLE ELI EVANKOVICH
HONORABLE SETH GROVE
HONORABLE RICH IRVIN
HONORABLE WARREN KAMPF
HONORABLE RYAN MACKENZIE
HONORABLE STEVEN MENTZER
HONORABLE TEDD NESBIT
HONORABLE MARGUERITE QUINN
HONORABLE BRAD ROAE
HONORABLE CURTIS SONNEY
HONORABLE MIKE TOBASH
HONORABLE ANTHONY DELUCA, DEMOCRATIC CHAIRMAN
HONORABLE RYAN BIZZARRO
HONORABLE DOM COSTA
HONORABLE MARGO DAVIDSON
HONORABLE TINA DAVIS
HONORABLE JASON DAWKINS
HONORABLE MIKE DRISCOLL
HONORABLE MARTY FLYNN

BEFORE (Cont'd):
HONORABLE ED GAINEY
HONORABLE ROBERT MATZIE
HONORABLE PERRY WARREN

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Pennsylvania House of Representatives
Commonwealth of Pennsylvania

I N D E X

TESTIFIERS

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SUBMITTED WRITTEN TESTIMONY

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(See submitted written testimony and handouts online.)

P R O C E E D I N G S

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MAJORITY CHAIRWOMAN PICKETT: Good morning, everyone. Good morning. Since it is 9:00 a.m. and we do have a rather long hearing today, I would like to get started. I'd like to call the public hearing of the House Insurance Committee to order.

We are here today to hear testimony on House Bill 161. It deals with drug price transparency.

Before we get started with that, though, I would like to have each of the Members introduce themselves and tell us where their district is. So I'll start right here with the gentleman on my left.

REPRESENTATIVE DAY: I'm Representative Gary Day, and I represent portions of Lehigh and Berks Counties.

REPRESENTATIVE EVANKOVICH: Eli Evankovich, representing the best parts of Westmoreland and Allegheny Counties.

REPRESENTATIVE MENTZER: Steve Mentzer, Lancaster County.

REPRESENTATIVE: [inaudible].

REPRESENTATIVE: [inaudible].

REPRESENTATIVE CULVER: Linda Culver, Northumberland and Snyder Counties.

REPRESENTATIVE NESBIT: Tedd Nesbit, Mercer and

Butler Counties.

REPRESENTATIVE ENGLISH: Hal English, Allegheny County.

REPRESENTATIVE DAVID: Sorry. Tina Davis, Bucks County.

REPRESENTATIVE DRISCOLL: Mike Driscoll, northeast Philadelphia.

REPRESENTATIVE WARREN: Perry Warren, Bucks County.

REPRESENTATIVE COSTA: Dom Costa, Allegheny County.

DEMOCRATIC CHAIRMAN DELUCA: Tony DeLuca, Allegheny County.

REPRESENTATIVE DAWKINS: Jason Dawkins, Philadelphia County.

MAJORITY CHAIRWOMAN PICKETT: And I'm --

REPRESENTATIVE DAVIDSON: Margo Davidson, Delaware County.

MAJORITY CHAIRWOMAN PICKETT: Sorry. Everybody? Is that everybody? I'm Tina Pickett, Bradford, Sullivan, and Susquehanna County.

I'll start off by saying, in recent years, constituents have seen ever-increasing prices for new and older drugs. There have been numerous examples of escalating drug prices in the news media. Business owners,

especially small business, see this increase in drug prices reflected in higher healthcare premiums for the business and for its employees.

I'm looking forward to hearing further discussion today. We have a full agenda. I ask each testifier to summarize your remarks, as we have your written testimony. And, Chairman DeLuca, I think you would like to say a few opening words also.

DEMOCRATIC CHAIRMAN DELUCA: Thank you, Madam Chair.

Good morning, everybody. And let me, first of all, thank you, Madam Chair, for calling this hearing today and cosponsoring House Bill 161, pharmacy transparency legislation.

I want to thank also all the Members of the Committee and everyone here who will be testifying on this important topic.

We are in a time of increased transparency across all aspects of government and entities regulated by the government in order to benefit the public. Yet the industry we will discuss today has a direct, significant impact on the public, and it continues to operate with little to no transparency.

Over the years, pharmaceutical manufacturers have made great strides in life-sustaining and even lifesaving

medication. Let me specify again they have made great strides on the medication, sustaining, lifesaving medication.

I myself, as many of you know, have benefited from some of the advances in the pharmaceutical industry. And today, I praise them for the work they do with all sincerity.

With that said, we cannot overlook the endless statistics and newsworthy headlines of huge price increases in this industry that ultimately affect the consumers who are our constituents. Now, I know the pharmaceutical industry will talk about their extraordinary research and cost to bring a drug to market, but they don't talk about government grants or education grants they may receive that may help with some of those costs. They will talk about how rebates decrease the actual costs and how couponing benefits the consumers in their actual costs.

But what they don't speak about is the actual cost charge for the drug and the freedom the industry has to raise the drug pricing whenever they feel like it. What the industry does not talk about is the health insurers who are actually picking up the tab for the real cost of the drug, not the copayments consumers have to pay. Even after the price is negotiated by the insurer or PMB with the manufacturer, the cost to the insurer may still be in the

hundreds, thousands, or even tens of thousands and yes, even hundreds of thousands of dollars.

What is significant about the discounting when the price continues to rise? The manufacturers can just increase the cost to make up the discount. What the manufacturers don't speak about are the health insurance premiums that are increasing in part due to continual pharmaceutical increase in cost.

Now, there are plenty of drugs we could name manufactured by specific companies that continue to raise the prices of their drugs seemingly as they wish. When the health insurers have to raise premiums to keep up with increased drug costs, this affects everyone, ladies and gentlemen. Higher premiums affect our employees, our employers, who are our constituents, providing health coverage to their employees, individuals, again, our constituents. Purchasing health insurance on their own must pay the added costs when they pay their increased premiums.

Cost-sharing is also an increasing burden on the consumers as employers' insurers have no choice but to add some skin in the game for consumers as everyone tries to grapple with these increases in cost of pharmaceuticals. Pharmacy costs are a major driver in causing health insurance premiums to rise. As a recent HHS report

published in the *Health Affairs* on healthcare spending, in 2015 it stated prescription drugs account for the third-largest share of health sector, 10 percent behind hospital care at 32 percent of the share and spending on physician services at 20 percent a share. However, prescription drugs led the pack in terms of overall price increases with 9 percent increases in 2015 compared to the average of a 6 percent increase in both hospitals and physician services. At 9 percent, prescription drugs are the leading driver of increased healthcare system, according to the report.

This rate of inflation increases should be concerning to all of us. In fact, even our new President Trump has raised the issue of transparency in drug prices in a recent press conference.

Ladies and gentlemen, the problem is real and it needs to be addressed. We need to start the conversation on the national and State levels. And this bill goes a long way towards doing that.

Now, let me say nothing in this bill is in concrete. We can make it a better bill on behalf of the consumers. We are open for all the stakeholders, myself and Madam Chairman, to listen to you, to try to make it a better bill.

And let me say this: Senator McCain has introduced a bill in Congress that will also address the

transparency issue.

So again, I want to thank you, Madam Chair, for this opportunity. I know I went a little long with my statement, but this is an important issue and I thank you again.

MAJORITY CHAIRWOMAN PICKETT: Thank you, Chairman DeLuca, for that opening.

And we'd also like to take note that Representative Gainey has joined us and Representative Quinn.

We will now go right ahead with our testifiers. We have the Pennsylvania Insurance Department first, Teresa Miller, the Pennsylvania Insurance Commissioner. Please go ahead when you're ready, Commissioner.

MS. MILLER: Thank you. Good morning, Chairwoman Pickett, Chairman DeLuca, and Honorable Members of the House Insurance Committee. It's a pleasure to be here, and I thank you for the opportunity to talk about what I agree is also a very important issue.

Pharmaceutical costs are really rising out of control, rising faster than any other costs in our healthcare system. National prescription drug spending is projected to have grown by 8.1 percent in 2015 after rising over 12 percent in 2014. But that's not going to be the end. Prescription drug prices are projected to continue to

grow year over year for the foreseeable future. And they're growing at a rate faster than any other area of healthcare spending.

In a nation with the highest healthcare costs in the world, where healthcare spending is expected to exceed 20 percent of GDP within the next decade, and where the median per capita healthcare spending of almost $10,000 in 2015 was over 17 percent of the average household income of American families. This trend cannot continue and must be moderated.

I applaud this Committee's efforts to start a dialogue on pharmaceutical costs and examine what can be done to reduce those costs and to make them more transparent.

As you know, last year, I approved significant health insurance rate increases in the individual market, and I know that there are Pennsylvanians who struggle to pay for those premiums. Yet the rate increases were justified based on the cost of covering this population, and insurance companies reported that the rising cost of pharmaceutical drugs was one of the major driving factors of these increases. And in fact rate-filing documents showed that in the individual market, pharmaceutical drugs rose from 13.6 percent of enrollee healthcare claims in 2014 to 21.4 percent in 2015. That's a 57 percent increase

in one year.

If we want to make health insurance more affordable, we need to make the health care that health insurance pays for more affordable, and prescription drugs are a huge part of that.

House Bill 161 would require prescription drug manufacturers to disclose to the Insurance Department certain information for high-cost drugs or drugs that have increased in cost rapidly. The information to be disclosed would include costs related to research and development, clinical trials, materials, marketing, and financial incentives. This transparency is really important and the first step towards addressing the rising cost of prescription drugs.

I would just very briefly flag that the enforcement mechanism in the current bill does raise some concerns in terms of the impact on consumers, but this is something that we look forward to working with the Committee on as this bill progresses and are happy to help ensure that, as we bring more transparency to this important issue, we do so in a way that's protective of consumers.

The Insurance Department has no direct regulatory authority over prescription drug costs. As the insurance regulator, our role is to make sure that insurance

companies are appropriately covering certain required prescription drugs and access is being provided in a manner that is not unfairly discriminatory.

I don't think there's a silver bullet for addressing the costs of prescription drugs or really any other aspect of our healthcare system for that matter. And, unfortunately, many of the issues with the pharmaceutical industry can only be dealt with at the Federal level. But having said that, I do think there are some steps that we can take, and there is no better place to start than increasing the transparency related to drug pricing in the Commonwealth.

I'm a big believer in transparency, as some of you know. Transparency, I think, is absolutely critical to understanding complex problems like how we can make health insurance more affordable. And since passage of the Affordable Care Act, we've made significant progress in providing more transparency around health insurance. For example, Pennsylvania, like many States, has significantly increased the transparency of our rate review process so the public has better information about what's driving health insurance rates.

The ACA also did take steps to limit insurance company spending not related to health care. We know the reason that health insurance is so expensive is because

health care is expensive. If we are going to make health insurance more affordable, we need to find ways to address the underlying costs of health care.

Unfortunately, the Affordable Care Act didn't do enough in this regard, and I think that is one of the very fair criticisms of the law, but it is time to address the underlying healthcare costs driving premium increases and transparency in this area is absolutely a critical first step.

So, again, I applaud this Committee for taking on this issue, for having this hearing today and look forward to working with you as this bill progresses and really on any other issue that helps address those underlying costs of care that are driving premium increases. Thank you.

MAJORITY CHAIRWOMAN PICKETT: Thank you, Commissioner Miller.

I would like to take note that Representative Brad Roae has joined us and also Representative Curt Sonney.

And, Chairman DeLuca, you have a question for the Commissioner?

DEMOCRATIC CHAIRMAN DELUCA: Yes. Commissioner, since we are talking about transparency for the pharmaceutical industry today, I hear a lot of comments about the insurance industry. Do we need to also talk

about transparency for the insurance industry, too?

MS. MILLER: Absolutely. I think -- you know, I mentioned I'm a big believer in transparency and I think transparency for all areas of our healthcare system is absolutely critical. You know, I think health insurance and transparency around health insurance is certainly part of that equation.

In fact, you know, when you look at our department and some of what we've done over the last couple of years, I think it's really been aimed at providing more transparency around health insurance. I mentioned in my testimony that we made significant changes to our rate review process. We're making more information in the rate filing documents that insurance companies provide to us available to the public and earlier in the process because we believe it's important for people to be able to see those documents and weigh in as we make our decisions.

But we've also significantly enhanced consumer-facing materials. We've tried to do a better job of putting good information in the hands of consumers when they need it so that they can help make more informed decisions. For example, this year, we partnered with a group called Consumers' Checkbook to put together a website that helps consumers compare plans. It has really good information that they need about those plans to help them

make those decisions. We've tried to do things like that. We've put together videos that explain our rate review process to people, that explain what you should think about when you're making decisions about buying health insurance, how to use your health insurance.

So we've been trying to make issues around health insurance more transparent, which is important, but I think I would also say, you know, there's certainly more to be done in this area. I've been really pleased to be a part of Health Innovation agenda of Governor Wolf's and the agenda that's being led by Secretary Murphy. And the Insurance Department has been leading health insurance and healthcare price and quality transparency efforts related to that innovation agenda. And I think the goal really is how do we do a better job giving consumers information they need so that they can make informed decisions about their health care? And we don't do that well today.

I will tell you a short story and I will protect the innocent so I won't list insurance companies or certainly names of people, but I was just the other day talking to a woman who now has to pay for some vitamin injections. And she's got a deductible so she has to pay for these, and I suggested to her -- they're really expensive. They're about $150 a month, and she gets an injection every month. And I said, well, you know, I would

reach out to -- I was trying to be helpful. I said, you know, I would reach out to your insurance company and ask them if they can help you find a provider that might have -- I mean, it's probably the same injection anywhere you go so if you can find a provider that has it more cost-effective, not only does that help you now, but then when you're through your deductible, it'll help the insurance company. And, again, I thought I was being helpful.

A couple hours later she came back and said, you know, I'm really frustrated right now. And she had several calls with the company, several tries at the website to try to find a provider and try and get the information she was looking for and at the end of the day just came up with absolutely nothing. So all I did was really frustrate her, and so I don't think she'll be coming to me for advice anymore. But it just showed me that we really need to do more in this area to provide people information so they can make good healthcare decisions.

DEMOCRATIC CHAIRMAN DELUCA: Thank you, Commissioner.

Thank you, Madam Chair.

MAJORITY CHAIRWOMAN PICKETT: Thank you.

I will also note that Representative Ryan Mackenzie has joined us, and I believe Representative Evankovich has a question.

REPRESENTATIVE EVANKOVICH: Yes, thank you, Madam Chair.

Ms. Commissioner, we're talking about two products here that we all need, I mean, we all use. You know, we all at some point in our lives need pharmaceuticals, and certainly we all need insurance. I mean, we certainly wouldn't want to pay out-of-pocket the full cost of our medical care, certainly not the full cost of our pharmaceuticals. That's why we buy insurance in the first place, right?

One of the questions that comes to my mind as we're debating this bill is, you know, we are talking about pricing -- the bill talks about pricing up front rather than what the consumer pays, and because this issue has come to light, there's been a lot of discussions about what does the patient pay versus what is the insurer paying for that drug and then combined with the rebate that the pharmaceutical company might be giving the insurer. And insurance some cases -- I mean, I'm looking at a letter from Senate Minority Leader Jay Costa asking your office specifically, you know, whether or not there are situations where an insurer is covering the cost of a drug, getting a rebate, and charging the patient full cost. Are you aware of those types of situations, number one?

And number two, do you have any details that you

can share with us about that layer of costs to the patient? I mean, we're talking about the drug pricing, but if you look at what the patient pays and then how that dollar floats back into the various organizations, whether it's a PBM, whether it's a drug wholesaler, whether it's the manufacturer or the insurance company. Can you help shed some light on those things? Because that's just a little bit confusing for me.

MS. MILLER: Yes, Representative, thank you for the question. And I did receive that letter from the Senator, and I think we got that just a little bit ago. It's something we're looking into. Today, I'm sorry I'm not able to share any additional information with you because we're still looking at that. But hopefully soon we will certainly be responding to that letter once we've had a chance to look into that.

REPRESENTATIVE EVANKOVICH: And on the issue of where the dollar flows from the patient going back.

MS. MILLER: Yes, I would need to look into that as well. Yes.

REPRESENTATIVE EVANKOVICH: Okay. Just very briefly, Madam Chair, so how many manufactured products does the Insurance Department currently regulate then?

MS. MILLER: How many manufactured products?

REPRESENTATIVE EVANKOVICH: Yes.

MS. MILLER: We regulate the insurance industry.

REPRESENTATIVE EVANKOVICH: So you don't currently regulate any manufactured product pricing?

MS. MILLER: Pharmaceutical -- no.

REPRESENTATIVE EVANKOVICH: Any manufactured product pricing, which is what this bill would purport to do.

MS. MILLER: Right. My understanding in terms of House Bill 161 is that it actually just is a transparency bill that provides information, so I'm not sure I would go as far as to call it regulating anything. It really just -- as I understand it, unless I'm missing something, it's really a transparency bill.

REPRESENTATIVE EVANKOVICH: And currently, the Insurance Department does this in which areas?

MS. MILLER: So, I mean we certainly -- as I mentioned earlier, we do a lot in terms of providing transparency around health insurance because that's what we regulate, but I think when you look at the regulation we provide around health insurance, it certainly goes a lot further than this bill. I mean, transparency, as I said, is very important. It's really a first step. But this bill doesn't go any further than that. So, again, we regulate insurance companies and we do what we can to provide transparency around health insurance and the rates

and the forms that we get.

REPRESENTATIVE EVANKOVICH: And you mentioned in your testimony that one of the biggest reasons why certain health insurers were asking for premium increases that were subsequently approved was because of the increased cost of pharmaceuticals?

MS. MILLER: Right.

REPRESENTATIVE EVANKOVICH: So they were able to justify that increased cost of pharmaceuticals to your department to justify those premium increases?

MS. MILLER: Well, they give us claims information, and pharmaceutical costs are certainly part of claims information. That's part of how we make decisions about whether we're going to approve rate filing.

REPRESENTATIVE EVANKOVICH: And does that claims information include the out-of-pocket expense on behalf of the consumer?

MS. MILLER: No.

REPRESENTATIVE EVANKOVICH: So in your justification of allowing a premium increase, it didn't also take into account that patients may be paying a lot more out-of-pocket irrespective of their premium increases being asked for by the insurer?

MS. MILLER: Well, I mean, I think when we do our review of rates, we are certainly looking at all the

information the insurance company provides. At the same time we had a public hearing last year, and the reason was because we wanted to hear from consumers and those that would be impacted, and that certainly is part of our analysis is the impact on consumers. And part of that is recognizing how much they are paying out-of-pocket certainly.

REPRESENTATIVE EVANKOVICH: And so in your detailed hearings did you note that consumers were paying substantially more out-of-pocket irrespective of their premium increases being asked for?

MS. MILLER: We certainly heard that from consumers who testified.

REPRESENTATIVE EVANKOVICH: Well, I guess my question then is was the insurer including the cost of the drug -- so I am trying to understand. Were the insurers including the cost of the drug in the premium that they were saying they were outlaying in a payment but not in what the patient was also paying? And did they include in the cost of the premiums the rebates that were given back from the pharmaceutical company?

MS. MILLER: So, again, I mean, what we look for as we're reviewing rates is the claims data, so how much the insurance companies are paying out-of-pocket. And again, we look at a lot of different factors, but the

claims data itself is one of the major factors we look at.

REPRESENTATIVE EVANKOVICH: My apologies. So you don't take into account the rebate?

MS. MILLER: You know what? Honestly, I would have to go back and talk to our folks that review the rate filings because I don't --

REPRESENTATIVE EVANKOVICH: Okay.

MS. MILLER: -- know how the rebates factor into that.

REPRESENTATIVE EVANKOVICH: Okay. Thank you.

MS. MILLER: Yes.

MAJORITY CHAIRWOMAN PICKETT: And perhaps you could come back with some information --

MS. MILLER: Absolutely.

MAJORITY CHAIRWOMAN PICKETT: -- for the Committee on that.

I would like to note that Representative Matzie, Representative Tobash, and Representative Grove are with us today.

And I believe Representative Quinn has a question.

REPRESENTATIVE QUINN: Thank you, Madam Chair.

And it's great to see you today, Commissioner. Thank you for being here.

The previous question has brought something to

mind. If you're looking at the claims as the costs rise, does your office -- do you drill down into those claims? Because here's the reason I'm asking and I've told a couple people in this room the story, but just recently, my 22-year-old made a doctor's appointment, went out to the doctor's appointment, her foot was sore. By the time she was home from the doctor, I get a phone call -- and it was the day before election. I wasn't in a great mood to begin with. I was up there.

But I get a call and it was a pharmacy calling saying, you know, we look like we're eligible and confirming the mailing address for the drug. And I'm like why can't she get it at the Acme pharmacy? And I was kind of getting the runaround, so I scratched the surface a bit with questions, asked what the drug is. It was 800 milligrams of Motrin with Pepcid. I was asking, probing, well, what's this going to cost my insurance company? And three times I was told like I annoyed them. We told you this won't cost you anything.

The final question, you know, I got this, the insurance company will be billed $2,008, $2,008 for Motrin plus Pepcid. So it was probably like 10 bucks it would have cost me at the Acme for a month.

My point is when you get a claim, how do you know when to drill down to see that there's some type of -- I

hate to say it -- but just scam between whomever who's doing all this? I mean, that's a ridiculous amount of money, and my kid at 22, she would have taken that and I think a lot of people would have just taken it. And they said, well, this is just so convenient. It'll come to your house. Are you aware of situations like this going on?

MS. MILLER: So, thank you for the question, Representative. I think what you've hit on is something I actually have seen in my own life working with providers and as a patient. I think oftentimes providers are concerned about what it's going to cost you and nobody thinks that it matters what it's going to cost the insurance company. And from our perspective at the Insurance Department, as I mentioned in my testimony, we don't have authority to regulate the underlying costs of care so we have no ability to go to the insurance company and say what you paid for that drug we just think is too high. What we can do is see how much the insurance company paid for the drug through the claims and then decide if their rate is reasonable going forward. But that's one of the difficulties, I think.

REPRESENTATIVE QUINN: But my point with this story is that we're looking at what this bill is going to do. It's looking at the overall cost for the production of that drug, trying to put their arms around research, post-

production cost, the whole ball of wax, yet here's a solid instance. And, you know, I know I'm not an outlier in this, but it's an instance where those manufacturing companies have nothing to do with it, yet an insurance company is about to get punched in the gut with $2,008 instead of $15. And I think that it's important that, as we look at this issue, we're looking at the whole situation and, you know, not just one segment.

Another thing is -- and I know we have a lot of testifiers, but as you said, we need to find the ways to address the underlying healthcare costs. I'm now 10 years on this Committee. This is not the first time we've had a hearing on the prescription cost prices. In an ideal world from your point of view, who else would you have testifying in a hearing? What other elements of the healthcare industry would you have in here to look at the whole underlying cost, not one segment of it?

MS. MILLER: Well, you know, frankly, I would probably ask that question of some of the insurance companies that you're going to hear from because they can talk about all of the claims that they pay and all of the -- that frankly we don't get all that into the details of where the money's going other than we know it's going to pay claims.

Pharmaceutical drugs, we know, are just the cost

that's rising the fastest, but certainly, you know, provider payments are a big part of insurance claims. And, you know, I mentioned that we know that health insurance is expensive because health care is expensive. And the ACA did limit how much in the individual, small group, and large group markets, how much insurance companies can pay in terms of admin versus actually paying for medical care.

So we know that it's the underlying healthcare costs, the payments to providers, the payments to hospitals. We know that's what's driving health insurance. So I think looking at all of those things would be important.

REPRESENTATIVE QUINN: Okay. Thank you.

MAJORITY CHAIRWOMAN PICKETT: Thank you.

Representative Tobash, you have a question.

REPRESENTATIVE TOBASH: Yes. Thank you, Madam Chair. And thanks for this hearing.

So this is important. I mean, we are so concerned about unaffordable insurance costs. And, Commissioner, I'm happy you're here testifying and I applaud Representative DeLuca for bringing this issue forward.

So outrageous insurance costs, unaffordable, outrageous pharmaceutical costs, and then we talk about this term transparency. Transparency, I get it. It's very

attractive in the marketplace right now in our psyche, right? We want to be more transparent. And certainly, I think that we've got a higher level of awareness about some of these issues. I mean, we see EpiPens, the cost of them being thousands of dollars and, wow, we shine some light on that. The next thing you know the cost of EpiPens is coming down.

So I think it's a good endeavor that we're going through this, but then, you know, when you drop down -- and I think that Representative Evankovich, you know, kind of mentioned it. So we talk about regulation and then we talk about overregulation and then we talk about mandates, and those are all things that drive up the cost of doing business. So we want to be very effective, and we're asking to mandate these manufacturers to provide additional information, which very well may be important to the consumer, to the end consumer, and to the department and whether or not they're going to approve rate increases. Are they providing this information to other States, to other organizations? Are we asking them to do something that is very unusual here?

I'm trying to get at the effectiveness and the cost that we're adding into the process in the name of driving down costs. Sometimes I call it the Bernie Madoff effect. You know, Bernie Madoff steals $20 billion from

people, and now we've regulated an industry that has just driven up the cost of delivering financial products to many end users, many consumers. Do you think we're going down that path here?

MS. MILLER: You know, thank you, Representative. I don't. I mean, I've heard the term now a couple times, regulating this industry with this bill. And maybe just because I'm so close to the regulation of the insurance industry that it's hard for me to think of this bill as regulation. You know, we're not subjecting pharmaceutical companies to financial exams to make sure they have money to pay claims like we do with insurance companies. We're not doing market conduct exams. We're not reviewing policies and rates and all of those things.

So the insurance market and the insurance industry is heavily regulated, so I think the term regulation makes sense there with what we do with insurance companies. Providing information so that we can make it transparent, I don't view that as regulation. I view that as just making information available.

As I read the bill, it doesn't actually require us to do anything further other than simply making information available. And as you said, I think transparency can be very powerful because when it's in the light of day sometimes that drives change in and of itself

without really regulating and going further.

I have a hard time viewing this bill as really burdensome or regulatory in nature for the pharmaceutical industry. It strikes me that we're asking for information that we then want to put out there and it doesn't go any further. And frankly, as I mentioned earlier, the pharmaceutical industry, really there's limits in terms of what we can do at the State level. It's really a Federal issue.

So I think this is something we can do at the State level. I think it's hard to say it's burdensome to provide this information. But I don't have the information -- there may be others in the room here who do -- about what other States do, but I don't have that information.

REPRESENTATIVE TOBASH: Yes. Good. So I understand that you may not be the -- you know, we should maybe be asking this question of every testifier to see if they're doing it elsewhere. But you have worked in this space in other States, in the healthcare industry in other States. Have you seen it in your previous positions where they have been asking for this type of in?

MS. MILLER: When I was in Oregon as the regulator, we did not collect this information at the time. That was years ago, but we didn't.

REPRESENTATIVE TOBASH: Sure. Thank you very

much.

MS. MILLER: You're welcome.

MAJORITY CHAIRWOMAN PICKETT: Thank you.

Chairman DeLuca, you have one more question.

DEMOCRATIC CHAIRMAN DELUCA: Thank you, Madam Chairman.

And since we brought up some good questions from the Members here, I just want to say one thing. We're not trying to -- there's nothing in here that regulates this industry. This is asking for transparency, information that we as taxpayers help them provide to get the money to do a lot of this research and development. So it's the taxpayers' money. And also the fact is that would you agree that this industry is a monopoly? Is there a lot of competition? Does competition bring down prices?

MS. MILLER: I would absolutely agree competition brings down prices.

DEMOCRATIC CHAIRMAN DELUCA: Is there competition interest the pharmaceutical manufacturers?

MS. MILLER: You know, I'm not sure I'm the best person to answer that question. I certainly don't profess to be an expert in the pharmaceutical industry so --

DEMOCRATIC CHAIRMAN DELUCA: Well, I mean, it's not like, you know, you can go to a different insurer and buy insurance different places. If they have a drug, they

have a monopoly for, what, 15 years? So I can't get that drug. I have to buy it off the pharmaceutical, so I consider that a monopoly.

Thank you.

MAJORITY CHAIRWOMAN PICKETT: Thank you. Thank you, Commissioner. Seeing no other questions, thank you.

We now will welcome Tara Ryan from PhRMA. Welcome. And go ahead when you're ready.

MS. RYAN: Madam Chairwoman, Chairman DeLuca, Members of the Committee, I am proud to be here today to represent the pharmaceutical industry. And I'm happy that we were given a seat at this table to answer some of the questions that have been raised already and to talk a little bit about how the process works and give you a little bit of history that might be useful to this conversation.

As you are well aware, this conversation's happening in a lot of States across the country. There is no patient in the United States today that should be having trouble affording either their medicine or their health care, and I think that should be the starting point of this conversation. And in order to make sure that we're addressing this properly, it requires looking at the entire healthcare system, not just drug manufacturers and pharmacy benefit managers, not just insurers and pharmacies but

hospitals and providers and some of the other drivers of healthcare cost.

Most importantly, we should be addressing chronic disease, which is the biggest driver of healthcare cost increases and how do we solve that problem.

That said, I wanted to talk a few minutes about why PhRMA opposes House Bill 161, the transparency bill, and then I have some slides that might be useful in walking through some of the process if you'll allow me to go through those.

So PhRMA opposes this bill for a variety of reasons. One, I think that in the vein of transparency and doing things that we have heard from the Insurance Commissioner, patients are concerned with their out-of-pocket costs. That's what started this whole discussion. I think at the same time patients started feeling a bigger pinch in the wallet as a result of some changes that happened following the Affordable Care Act, we also had Martin Shkreli make headlines, we also had a hepatitis C cure come to market, and then we had the Mylan experience all sort of happening at the same time when we should have been focusing on the conversation about the fact that there were cures coming to market.

And instead, the conversation got very twisted by somebody that the media described as a pharmaceutical

executive who was really a very, very shady hedge fund guy who did something very disingenuous and purchased a drug that treats a very small but sickly population of people, increased the price so dramatically, making it entirely unaffordable, and changing the whole conversation about what's happening in health care.

This is an unusual bill in that it is very different from the Vermont bill that did pass last year, which is the only bill in the country that addresses pricing increases. Vermont did something very different. They looked at -- they required information at a maximum of 15 drugs, including brands and generics, and they required companies to report certain information.

As a result of the reporting of the drugs that were subject to the reporting last year, which ended up being 10 drugs, seven of them were generics. And all of the information that went into the Attorney General's Office came back with information that I think the Attorney General found that the rate increases were justifiable.

That aside, to answer Chairman DeLuca's question, that's the only State in the country that has done something and actually put it on the books. And it is a very different situation than what we're seeing in House Bill 161.

House Bill 161 would rely on average wholesale

price, which is the price that manufacturers don't engage in. It's a price that takes place between PBMs and plans and plans and pharmacies. It's a grossly inflated price, and it's one that nobody pays. As a matter of fact, there has been litigation on this, and it's not a good starting place. Most of the legislation we've seen would require reporting based on wholesale acquisition cost, also a price that nobody pays but may be a better starting point to a conversation because it then allows us to have a conversation between list price and net price, which gets into the discussion about the rebates that manufacturers pay and how that process works. And maybe I can answer some of the questions that the Insurance Commissioner was unable to answer only because she doesn't have the insight into some of the processes.

But anyway, in addition to that, there's this significant reporting requirement, which I would say it creates a regulatory burden for our industry. Asking manufacturers to disclose proprietary information about pricing certainly puts them at a disadvantage in what is a very competitive marketplace. The FTC has sent out a report years ago that said disclosing this would not reduce prices but would end up increasing prices overall.

More importantly, what the bill does is says that if a manufacturer doesn't report on March 1st then the

insurer is allowed to refrain from including that drug on the formulary. So it puts the insurer in the position of keeping access to a needed medication from a patient, all based on whether or not a manufacturer reports this enormous list and very burdensome list of information.

This bill doesn't understand the process of how things work because manufacturers negotiate with pharmacy benefit managers, the PBMs, and the contracts that they negotiate can last for a number of years. And the discounts can be from 20 percent to 30 percent to 40 percent to 50, 60 percent discount. That's the end of the negotiations that the manufacturers engage in. Manufacturers negotiate with PBMs -- PBMs, customers, or the insurers -- and the insurers work with the pharmacies. So once our companies negotiate those rebates, that's the end of our story. Then, what happens is the PBMs create their formularies and they include on their standard formulary the drugs that they've negotiated prices for, and they then share that with their insurer customers, who use those formularies with all of the patient enrollees that they have in their plans.

What happens with that rebate is out of our control once we negotiate that rebate. So we negotiate a rebate. It may be in a contract with a PBM that goes for years, and this says that after we have negotiated that

rebate, the next year may be -- if one of our companies doesn't file this report, the insurer can keep that drug from being put on the formulary even though our members have made a good-faith effort to negotiate a discounted price so that patients could have access to that drug.

That's my initial read of this and our biggest concerns with this. The impact of this is that it's going to negatively impact patients, and it puts an enormous burden on the industry, on an industry that has no impact on how patients actually access medicines. We negotiate rebates. Pharmacy benefit managers create formularies. Insurers create formularies and benefit design, which is how patients interact with the system in that your insurance benefit design is what dictates how much you, as a customer, pay out of pocket. You may have a copay on your drug. You may have a coinsurance on your drug. And we can talk a little bit more about that. We have nothing to do with that as an industry. That all happens downstream.

So looking at one part of this very complex system and calling it out and saying it's going to do something to change prices doesn't generally make sense. So I think we should -- I heard this morning that the Governor's budget includes language about an all-payer claims database and that having all of that information

shared would be a way to sort of have a better understanding of what is actually driving costs in the healthcare system and that the insurers actually came out and said that that would require them disclosing proprietary information that would then increase healthcare costs. So I think it's an odd thing that sharing more information would drive up costs and would disclose proprietary information.

So let's talk a little bit if you don't mind -- can you see the slides from where you're sitting? Yes, this is kind of an odd system. You have the slides in your deck. We have a packet of information, and I did copy the slides for you. So if we can walk through those, I think it might be useful to you. And I'm happy to answer questions along the way if that's helpful to you.

Inside your packet you not only have the slides but you also have information about international pricing. You have information about information that the pharmaceutical industry has to disclose regularly that's already publicly available information. Much of what's actually required under this is publicly available information. And I think you have our statement in opposition.

So if I may, I would like to just walk through this quickly. The biopharmaceutical industry today is at

the leading edge of science. There are more than 7,000 drugs in the pipeline. That means they're somewhere between clinical trials and FDA approval. Of the drugs in the pipeline, 70 percent of those drugs have the ability to be first-in-class, which means they'll treat disease in a way not available to patients today. Seventy percent have the ability to be first-in-class.

Of those 70 percent, 42 percent have the ability to be personalized medicine. Medicine is going in a very, very different direction. Forty-two percent have the ability to be personalized, but of that 42 percent, 73 percent of the oncology medicines have the ability to be personalized medicine. So we are actually going after really fighting things like cancer.

Developing medicines is a very challenging undertaking. I guess we should let the people who are looking at the -- it's a very challenging undertaking. It's incredibly complex. And as we get into this new world of personalized medicine, it's becoming increasingly more complex. Only 12 percent of drugs that go through the pipeline ever get approved by the FDA. So we have almost a 90 percent fail rate. It's an enormously high risk that our companies take on when trying to develop a drug.

Most of the drugs that fail, fail sometime in the late phases of clinical trials. You just probably heard

about an Eli Lilly drug. I think it made a lot of headlines recently. Eli Lilly has been looking for a drug that would delay the onset of Alzheimer's. They've been working to bring a drug to market for 30 years. They finally got to the point where they thought they were just going to have something approved recently; it didn't get FDA approval. Thirty years they've been researching just to find a drug that would delay the onset, and they have not been successful in bringing one drug to market.

So what we don't want to do is put something on the books that is going to disincentivize our companies from continuing to do the research that we think will be, you know -- doing something that would delay the onset of Alzheimer's is a game-changer. The biggest cost that States are paying right now in the Medicaid program is for long-term care. The enormous amount of money that would be achieved by delaying the onset of Alzheimer's, it's astronomical. So we don't want to do anything that's going to disincentivize the research that's going on.

If you're looking at asking a company to report on their research and development for a drug, you have to think that it takes 12 years to bring a drug to market. Eli Lilly's been researching a drug for Alzheimer's for 30 years. If that drug finally comes to market, how are they going to be able to go back and calculate what it cost them

to bring that drug to market? It's not a linear system. You don't start on day one and go through the process. You start on day one and in year three maybe you realize it's not actually going to treat this, it's going to treat that. It's a very complex process even in research and development. You start with 10,000 compounds and you might come out with one drug at the end of it.

In addition to that, that one drug that makes it to market has to recoup the cost for the research and development of that drug, the research and development for all the drugs that failed. And it has to provide a revenue source for the continued research because companies don't necessarily have a whole bunch of companies that are coming to market in one year. It might be that one drug comes to market and that's the drug that's bringing in the revenue to continue the research for other drugs for a period of years.

If you just look at that slide, you can see, you know, Alzheimer's, 123 drugs with success at only four, and none of these delay the onset. These just help with sort of dealing with some of the impact of Alzheimer's. Melanomas, 96 tries, seven successes; lung cancer, 167 tries, 10 successes. It is a very long, high-risk process bringing a drug to market.

But the drugs that do make it to market may be

the most cost-effective means of preventing and treating disease. It's far less expensive to treat a patient with medicine than to have them having to go in and deal with providers and hospital care. Hospital costs are rising three times faster than the prescription drugs spent.

A 2013 study by the IMS Institute for Healthcare Informatics estimated that the U.S. healthcare system could save $213 billion annually if we could just get patients to use their medicines properly. That's just getting people to be adherent to their medicines. And if we could get more people treated and get them to be adherent, the numbers are staggering, you know? We want to reduce hospital care. Hospital care creates a whole lot of other potential problems with staph infections and all these other things. We want to keep people healthy and keep them out of the hospital.

Better adherence to medicines can lower total healthcare spending for the chronically ill. Again, the people we want to capture are people with chronic disease who are taking multiple medicines. We want to make sure they're seeing the providers when they can, taking their medicines when they can.

But because brand drugs are unique, I thought it's important to talk about what we do just in the State of Pennsylvania. In order to participate in the State

Medicaid program, our companies are required, pursuant to agreement that was made a long time ago, to pay a rebate on every drug in the Medicaid program. In addition to that contract that we -- in order for our drugs to be covered in Medicaid, and all drugs have to be covered in Medicaid, our companies will pay a rebate. We also then agreed to pay a rebate in the 340B Program and the VA Program. They're all tied together. You do one, you do all three.

Our companies decided a long time ago it's important for everyone in Medicaid to have access to the same drugs that people outside of the Medicaid program could. In 2015 alone our companies paid $929 million into the Pennsylvania Medicaid program. That's because prior to the Affordable Care Act, our companies paid 15.1 percent rebate on every drug in the Medicaid program. Following the Affordable Care Act, that number increased to 23.1. So for every drug that is in the Medicaid program, our companies are paying a 23.1 percent rebate. Generics pay a 13.1 percent rebate.

In addition to that, there's a consumer price index protection provision put in so that if our drug prices rise at a certain rate, faster than the CPI, the Medicaid program gets the benefit of that. And then we have the Supplemental Rebate Program, which says that if you're looking for a certain placement on your preferred

drug lists, our companies will pay a little bit more to get product placement so that patients will have access to their medicine. That's a role that's unique to drug makers. Brands and generics are the only ones who pay into the system to have access to our medicines.

Now, let's talk a little bit about the value of competition. We hear a lot of information about -- it's actually been raised this morning about the fact that our companies don't put any into research and development. The NIH is the one that takes care of all of that. In 2015 alone, PhRMA member companies -- that's not all brand drug makers; we represent a limited number of brand drug makers -- our companies spent $58.8 billion on research and development in 2015. That is almost double the entire NIH budget. So our companies are out there getting it done. They take the basic research from NIH, which is shared with us and which is shared with defense, which is shared with a lot of others, and they turn that into the medicines that we as patients take today.

It is a very competitive market. A patent begins to run when the research and development is happening. So a patent that might be 20 years starts to run and it runs the whole time the clinical trials are happening, it runs while the FDA approval process is going on, and then it continues to run once the drug hits the market and patients

have access to that.

And we never think about the fact that -- we talk a lot about when generics come, the price goes down, but there is also enormous competition. Generally, there's about a 2.3-year window of time before a brand drug has a brand drug competitor, and that brand drug competitor can impact the market share that the original drug had. So if you've got a drug that is easier to administer, that is more efficacious for a larger population of people, things like that, you can take that market share away quite quickly. And if you only have a limited time, say, 10 years, to recoup your money and to make up for all the failures and to provide a revenue source for ongoing research and development, that window closes as your competitors hit the market.

The most unique thing I think about the system is that we also are the only part of the healthcare system where you know that costs are going to go down just by nature of the generic model. So once the drug goes off patent, then the drug becomes a generic. It takes about three months to capture about 90 percent of that market. So it's a very quick turnaround when a brand drug goes off patent. Back in 1984, about 19 percent of the market was generics. Today, it's almost 90 percent. So one in 10 drugs that are prescribed are brand drugs. Nine in 10

drugs that are prescribed today are generic drugs.

The interesting thing about that is, despite the fact that we lose almost our entire market share as soon as the generic becomes available, all of our manufacturers retain all of the liability that goes along with being the brand drug maker.

So medicines are the only part with a built-in cost containment, so this slide just talks a little bit about how -- I hate the fact that the word percutaneous coronary angioplasty is on that slide because I'm not a doctor and I can't imagine having to say that more than once in a year, but those prices are going up. In 2005, that procedure cost patients more than $47,000, and in 2013 that same procedure increased to cost about $80,000. There are no built-in cost containments in any other part of the healthcare system.

If you look at atorvastatin, which is a cholesterol-lowering medication that I think most people are aware of, it cost $2 in 2005 and it's now just 15 cents per dose.

And we heard a couple of years ago there was a lot of discussion about the patent cliff and all of these blockbuster drugs were going off patent, and I think a lot of people thought that that patent cliff was going to end, but if you look at just this slide, we're going to see $93

billion of brand sales projected to face generic competition through 2020. And if you include biosimilars in that, savings from brand drugs going off patent are projected to be over 1.5 times larger from 2017 to 2021 than they have been in the last five years.

So the benefit of this is the healthcare system has to do nothing. Once those drugs go off patent, the savings are achievable by the State through your Medicaid program and by patients by virtue of the fact that they're put onto formularies immediately. And if they don't need to take the brand drug, they get the benefit of being able to take the generic, which saves insurers costs, which saves State money.

So this is just some background on putting cost in context. Since 2000, biopharmaceutical companies have brought more than 500 new medicines to market, yet the spending on retain medicines has stayed stable. In 1960, 10 cents of the healthcare dollar was spent on medicines, and that same number, by government actuaries, is expected to remain stable all the way through 2025.

If you look at not just the retail spin but if you look at medicines that are dispensed at the hospital and through provider offices, that increase goes up to about 14 percent. That includes all of the new drugs that are coming to market, and the reason that this happens is

because of the generic system that we have in place.

And this gets to some of the conversation that was taking place a little bit earlier. Our companies pay significant rebates. Everybody sort of talks about the rise in drug spending in 2014. I'll just put a little context around that. In 2014, you had Medicaid expansion, you had the hepatitis C drugs hit the market, and you also had a year that was an anomaly in that almost no drugs went off patent. So there was kind of a fluctuation. But because of that, people like to highlight that in 2014 drug spending went crazy when really there's a reason for it. There's a rationale for what happened. And if you look at this chart, just after that we see that the rebates -- the prices started to go down.

Our companies, they pay -- you know, we hear about the $84,000 drug. The hepatitis C I'll use as an example, the $84,000 drug. Nobody was paying $84,000. Gilead is not one of our member companies, but they brought Sovaldi to market and they knew that they had competitors on their heels so they didn't want to negotiate rebates beyond what they had to pay in the Medicaid program. So they knew that they were paying 23.1 percent. That's about as far as they wanted to go. That was a decision that they made. But what happened was, as competitors came within the next year-and-a-half, we started to see the prices of

the hepatitis C drugs go down to 40 percent discounts, down to 60 percent discounts. They're now I think at about 65 percent discounts.

Headlines all over the country were saying the hepatitis C drugs were going to destroy the market; it wouldn't be sustainable; Express Scripts, which is one of the largest pharmacy benefit managers, was calling it a tsunami. And now, what they're saying is treat everybody with hepatitis C. The costs are so low. It's cheaper to get that medicine in the United States than anywhere in the world. It's a cure. We should be treating patients. What happened is competition worked. It did exactly what we said it was going to do. Competitors came to the market, the prices went down, patients are being treated.

If you look at this chart, the 12.4 percent, those are the list prices. The 2.8 percent is what's happening with net prices. So list prices are going up, and our companies are paying more and more and more in rebates to bring that down to the net price, which is actually what insurers and PBMs are paying for the medicines.

What happens with those rebates is out of our control. We pay those significant rebates to get drugs on formulary so patients have the ability to afford their medicines. What I know and will talk a little bit more

about this as we get into the supply chain is that patients pay coinsurance, not copays, but patients pay their coinsurance, which is when you have a higher-cost specialty medicine. Instead of paying a $5 or $10 copay, you pay a 20 or 30 or 40 or 50 percent coinsurance. They pay that on the list price. They don't pay that on the net price. They don't pay that coinsurance on the rebated price. And so if we're talking about why patients are starting to feel a pinch, we've got to be looking at insurance benefit design.

This graph that I have up now is very complex, and I think it helps at least visualize what goes on in the drug supply chain. You've got negotiations between manufacturers and PBMs, and PBMs and health plans, and health plans and pharmacies, and drug wholesalers and patients. It's a very, very complex program. And once you get out of just the negotiations between the manufacturers and the PBMs, everybody takes a slice of that down the road. Everybody -- they're all businesses and they're all making money on this supply chain. And they all have an impact on drug pricing, and they're the ones that have an impact on how a patient pays for their medicines.

MAJORITY CHAIRWOMAN PICKETT: Ms. Ryan?

MS. RYAN: Yes?

MAJORITY CHAIRWOMAN PICKETT: Pardon me. I hate

to interrupt but could you just like maybe highlight a few more things in your slides --

MS. RYAN: Yes.

MAJORITY CHAIRWOMAN PICKETT: -- and then let the Members study that on their own --

MS. RYAN: Yes.

MAJORITY CHAIRWOMAN PICKETT: -- and if they have further questions, we'll get back to you --

MS. RYAN: I'll do just the next two slides.

MAJORITY CHAIRWOMAN PICKETT: -- because I have some Members who want to ask questions so --

MS. RYAN: Yes.

MAJORITY CHAIRWOMAN PICKETT: -- and then we have to get in session --

MS. RYAN: I'll do just the next two then.

MAJORITY CHAIRWOMAN PICKETT: Great.

MS. RYAN: I think Chairman DeLuca asked the question earlier about whether or not our companies have monopolies on the market. I think the patent system is in place for a very specific reason, to incentivize companies to do the research and development to bring drugs to market. Our companies don't make widgets. They make very unique medicines to treat a very specific disease.

PBMs are the next player in the system in this very complex system. There are three PBMs in the country

today that cover 75 percent of every prescription written, three PBMs. They have been combining, they have been merging in the last couple of years, and now we have three PBMs who control 75 percent of the market. They have enormous leveraging power. They're the ones that negotiate with our manufacturers to increase the rebates. And I'll just give -- PBMs say at every hearing I've been to they don't set list prices. That's true. Our manufacturers have to set the list price.

But what happens is -- and I'll use the hepatitis C drug situation as an example. We had one of our companies that was one of the drugs that came to market after the Sovaldi drug, and they had read the headlines, the $84,000 drug. They were listening to what was happening, and they wanted to come in with a lower price so that they could get onto the formulary and patients would have access. And the PBMs said we're not interested in that. We're not making enough money on that spread between the list price and the net price, and their drug had a lot of trouble getting onto a formulary so that patients could have access. Three PBMs, 75 percent of the market.

And I'll end with this slide. We were talking about why patients care. Patients are experiencing more out-of-pocket because what's happened as a result of the -- specialty tiering started, I think, when Medicaid Part D

started. And it used to be that patients paid a copay. You also generally had first-dollar coverage for your drugs. So you might have had to pay down a deductible for your medical care, but you never had to do that when you went to the pharmacy counter. Your insurance kicked in.

Between 2012 and 2015, the number of plans that include medicines as part of the deductible has more than doubled. So now a patient goes to the pharmacy counter in January and instead of having your insurance kick in, you're paying out-of-pocket for that. And one of the questions was raised earlier, is there a time when the patient is paying more for their medicine than the insurer? That happens during the deductible. So you're paying 20 percent coinsurance on the list price of the drug during your deductible.

We know that patients pick their plans in about four minutes. They look to see what their premiums are. They pick one that they can afford. They don't know if their drugs are covered, if their doctor is covered, if their doctor is in network, if their hospitals are covered, what their out-of-pocket costs are going to be. But they know they can afford the premium, the pick the plan, and then they find out that their deductible is $2,500, $3,500, $4,500. And they get to the pharmacy counter. They used to have a $10 copay. Now, they have a $300 out-of-pocket

cost because they're paying a list price on their medicine during the deductible. So that's when a patient is paying more out-of-pocket than the insurer paid for the medicine.

So I'll stop there and I'm happy to answer any questions.

MAJORITY CHAIRWOMAN PICKETT: Thank you so much. We will ask for a question from Representative Evankovich.

REPRESENTATIVE EVANKOVICH: Thank you, Madam Chair, and I'll be quick in my questions.

Thank you, Ms. Ryan, for your testimony.

Did I hear you correctly in your testimony that pharmaceutical companies don't contract with insurance plans?

MS. RYAN: Generally, they don't. Generally, they contract -- there may be times when that happens, but they generally contract with PBMs, and they do multi-year contracts with PBMs.

REPRESENTATIVE EVANKOVICH: And so this type of new regulatory, this type of regulatory bill that's outlined in House Bill 161, this would -- and this chart that you put together, House Bill 161 would focus on the prices between here and here. But really what we're hearing from our constituents and from people in the State is that their concerns from the consumer is really what's being paid here. And I would just add there probably

should be a dotted line between the patient and health plan because we did hear from the Insurance Commissioner that patients are paying higher premiums because of pharmaceutical costs in their plans.

So I guess my question is do your member companies, does your association have an idea of for every dollar that this patient outlays -- because the patient doesn't know what piece of their premium is going to pharmaceutical costs --

MS. RYAN: That's right.

REPRESENTATIVE EVANKOVICH: -- versus administration versus profitability for an insurance company versus covered medical costs. They don't know that. They also don't know -- we just heard some examples. They also don't know that whenever they pay the pharmacy what part of that dollar is going to a PBM. They don't know what part of that dollar is going towards the actual cost of the pharmaceutical that was proffered to that pharmacy. So the patient really doesn't know, but this is where the concern is, right? I mean, we're all talking about patients' costs.

So do your member companies, do you guys have a sense of for every dollar a patient pays, how much of that dollar makes it way back over here to the manufacturer? Do we have a sense of that? Because that seems to be -- I

mean, we're talking about regulating this --

MS. RYAN: Yes.

REPRESENTATIVE EVANKOVICH: -- but we're not paying attention to where every one of -- every piece, every cent of dollar, where does it flow back to? You know, how much of that goes to the PBM? How much of it goes to the pharmacist?

MS. RYAN: Well --

REPRESENTATIVE EVANKOVICH: And, for the record, I am in no way against any of these players in here making money because they wouldn't exist if they weren't able to make money so that's not the genesis of my question. It's to understand we're talking about this word transparency. Where does it go?

MS. RYAN: Okay. So that's an interesting question and I don't know that I can answer it with how much of the patient's dollar goes back, but I do know that -- and this is in your packets -- brand drug manufacturers, brand drug, not generics, realize less than half of the total net of the prescription drug spent. So of all the money that's spent on prescription medicines in the healthcare system, brand manufacturers take 47 percent of that net. The supply chain entities take more than half of what the brand drug makers take. They take 27 percent of the net of all of the money that goes into the healthcare

spend. The supply chain entities take 27 percent of that, and brand drug makers that do all the research and development, take on all the liability and risk, make 47 percent of that. So I can't say to what a patient pays, but I do know overall on the healthcare spend how it breaks down.

REPRESENTATIVE EVANKOVICH: Thank you, Madam Chair.

MAJORITY CHAIRWOMAN PICKETT: Thank you.

Representative Nesbit.

REPRESENTATIVE NESBIT: Yes, thank you, Madam Chair. And thank you for your testimony.

Following up briefly on that, is there a simple explanation why I as a consumer can't walk into, let's just say Walmart, Giant Eagle, wherever, and say how much does this prescription cost? Because it's my understanding in researching for this that it's different cost at Giant Eagle, it's a different cost at Walmart, it might be a different cost in Philadelphia than it is in Pittsburgh. Is there a simple answer to why we just can't have a retail cost for what a prescription actually costs the consumer?

MS. RYAN: That's all part of the supply chain so we're out of that, but we do know that if you go onto a retail drug finder, RX.com or whatever those drug-finders are, you will find that every pharmacy around you will be

selling that same drug for a different price. We have no control over that or why that happens, but that's all part of the process in understanding what patients pay out-of-pocket.

REPRESENTATIVE NESBIT: Well, you say you have no control over that, but at the same time don't you -- and you used in your testimony rebated price, wholesale price, list price. You know, originally, though, don't you set the -- we'll call it the original price.

MS. RYAN: A list price.

REPRESENTATIVE NESBIT: Yes.

MS. RYAN: We set the list price and then we do the rebate. And once we negotiate that rebated price to the PBMs, then we lose control of that discussion because it's the PBMs and insurers that design the benefit package for patients. PBMs are only involved on the drug side. They only deal with drugs. Of course, the insurers deal with medical care and with the medicines, right? So their benefit package includes not just your drug coverage but your health coverage as well. And so they create a benefit package that covers all of that.

And then the pharmacy has a whole other set of things that happen that I'm not totally aware of. But, you know, there's an incentive for them to dispense generics. They make more if they dispense a generic than they do on a

brand, and there are dispensing fees that are involved, and all of that goes into play into what the patient pays out-of-pocket.

REPRESENTATIVE NESBIT: Now, in your opinion, though, does the marketplace start that original price that you said nobody ever pays -- obviously, there's, you know, billions of dollars involved. There's got to be very smart people that determine, hey, if we charge this, we're going to see a return. So, I mean, that's obviously --

MS. RYAN: So what goes into --

REPRESENTATIVE NESBIT: -- all factored in.

MS. RYAN: What goes into the drug pricing?

REPRESENTATIVE NESBIT: Yes.

MS. RYAN: Okay.

REPRESENTATIVE NESBIT: I mean, because ultimately that's what we're here for is to figure out --

MS. RYAN: Yes.

REPRESENTATIVE NESBIT: -- the drug pricing, but yet, seriously, there's a rebated price, a wholesale price, a list price, and you said in your testimony that the one price nobody ever pays so that's --

MS. RYAN: Right.

REPRESENTATIVE NESBIT: -- not a real price.

MS. RYAN: Right.

REPRESENTATIVE NESBIT: So to get at the --

MS. RYAN: It's like the --

REPRESENTATIVE NESBIT: -- transparency --

MS. RYAN: -- negotiating price like if you're buying a car --

REPRESENTATIVE NESBIT: Right, but if I'm buying a car, I can --

MS. RYAN: -- you know, go in and say, oh, I'll buy that car for $20,000 --

REPRESENTATIVE NESBIT: If I'm buying a car, though, I can go on the internet and I can say at, you know, this dealership it's going to cost $10,000; at this dealership it's going to cost $12,000.

MS. RYAN: Right.

REPRESENTATIVE NESBIT: But I can call -- this happened in my office two weeks ago -- and I apologize, Madam Chairman; I'll wrap it up -- but somebody walked in and said how much is this price? So we called a couple of the pharmacies and said how much is it? They couldn't tell us. So it's not like buying a car because I can't get an answer to the question of how much does it cost to go in --

MS. RYAN: Right.

REPRESENTATIVE NESBIT: -- as a retailer consumer.

MS. RYAN: So what the retail consumer is paying is out of our control because that's what the pharmacy --

the pharmacy sets that price, and it's based on your insurance. You know, it varies by insurer, it varies by pharmacy. It's all part of this complex problem, which is why I'm saying this bill, House Bill 161, doesn't solve the problem because it doesn't get at why patients are concerned about their drug pricing because they're paying more out-of-pocket and the headlines are telling them it's because of their prescription medicines. But really, there are a lot of other changes that have happened in the marketplace in the past few years that are impacting what they're paying. You know, one of the things that's happened is a change in benefit design, and patients are paying more out-of-pocket. And the burden is being shifted onto patients.

REPRESENTATIVE NESBIT: Okay. Thank you very much.

Thank you, Madam Chairman.

MAJORITY CHAIRWOMAN PICKETT: Thank you.

Representative Kampf?

REPRESENTATIVE KAMPF: Thank you, Madam Chair.

Ms. Ryan, maybe just a comment and then a couple of quick questions. I do have to say, Chairman DeLuca, I'm a little concerned about interfering with a system or a sector which does so much good for patients. I mean, you know, the research and development piece of this, which is

working on cures and treatments for all kinds of terrible diseases, anything that alters that status quo is, in my mind, something we have to be very careful about doing.

Ms. Ryan, one thing I just wanted to highlight and see if I get right, under the new high-deductible plan, a consumer is paying a list price, which is substantially over what the actual price is that, you know, you see some benefit from I guess in the reimbursement process. Did I get that right?

MS. RYAN: When a patient is paying down their deductible, when a patient is paying their coinsurance, they're paying on the list price. They're not paying on a rebated price and so they're paying more up front during the time that they're paying down their deductible because, one, they're paying on the list price; and two, no insurance kicked in to help them. So they're paying the full amount of what's required of them.

REPRESENTATIVE KAMPF: So before the advent of these higher deductible situations, I mean was anybody who got insurance or was Medicaid ever paying that list price anyway? Was that list price actually being paid by somebody?

MS. RYAN: The list price is generally never paid. The Medicaid program never pays it because Medicaid always gets the benefit of the rebate. In the commercial

market it may be smaller than that because Medicaid also always gets best price so there's never one sale in the commercial market at a rate that's lower than what Medicaid pays, but that doesn't mean that the patient's ever getting the benefit of that rebate.

REPRESENTATIVE KAMPF: Okay. All right. And then there was some talk I think from the Insurance Commissioner and maybe from one of my colleagues about prescription spending having gone up this year or last year by about 10 percent. What's the longer term? Are there projections from, you know, CMS, from the government on where those kinds of prescription drug costs are going to go and aside from this year or last year typically what have they been over the long haul.

MS. RYAN: I think after 2014, in 2015 the number came back down to 5.8 percent or something like that, and projections are that it will stay in line with the healthcare trend for the foreseeable future. So that's what the government actuaries are saying.

REPRESENTATIVE KAMPF: So healthcare trend meaning the trend of all the services that go in --

MS. RYAN: Yes, so --

REPRESENTATIVE KAMPF: -- the hospitals and --

MS. RYAN: -- we've come back in line, but we do know that looking at the government reports, hospital

spending is going to go up significantly versus the drug spend will stay more consistent with the overall trend.

REPRESENTATIVE KAMPF: And just lastly, does your industry have sort of a ballpark number on what the cost is to get a drug to market if it actually passes clinical trials?

MS. RYAN: It's about 10 years to bring a drug to market at the cost of about $2.6 billion.

REPRESENTATIVE KAMPF: Thank you.

MAJORITY CHAIRWOMAN PICKETT: Thank you. I have four more people who would like to ask questions regarding this subject right here, so could you pull those questions and answers as tight as possible?

Representative Tobash.

REPRESENTATIVE TOBASH: Thank you.

So I could understand it, insurance companies don't buy from Pfizer or Merck. Much of the cost is borne after that. This legislation addresses wholesale acquisition costs, and we have a lot of price that's affected after that. And it's your contention that we have a nonhealthy competitive-based wholesale market, which is driving up the cost. I get that, and we've talked about that a little bit.

But you also mentioned that most of the information here that is required already exists and is

publicly available, so why don't you just give the rest of the information that we're requesting here at very little cost?

MS. RYAN: Okay. Thank you for that question. I want to just go back. Did you say that I feel that we don't have a good competitive market in place?

REPRESENTATIVE TOBASH: The wholesale market. I mean, you indicated that there's only three major players in the wholesale market --

MS. RYAN: Okay --

REPRESENTATIVE TOBASH: -- after you release the product to them, and if it's not real competitive, maybe that's where a lot of the cost is coming from and this legislation doesn't address that.

MS. RYAN: Okay. I agree with that. I agree with the fact that this legislation doesn't affect that, and I think that that -- if we're looking at pricing, we have to look at the entire supply chain.

I'm sorry. Now I got totally caught up in that and I can't remember the second half of the question.

REPRESENTATIVE TOBASH: So, I mean, the second part is you indicated that most of the information that's being required here is already publicly available, so why not just consolidate it, add a little bit more information to it, and then we have the transparency that they're

requesting in the legislation?

MS. RYAN: Some of it is publicly available. Some of it we deem proprietary and we think it will impact the competitive nature of the market, and therefore, our companies don't want to. But what we feel is that, you know, we're seeing these types of bills in a lot of different States and they all do something a little bit different. And what we don't want to do is have a whole patchwork of laws that our companies have to follow with regulatory -- I mean, this says if you don't do this the way that we want you to do it, then an insurer can withhold your drug from a formulary.

So if you've got all these patchwork of States -- the administrative burden for our companies to go back and just do the research and development reporting that's required under this one -- and let's just use Lilly as an example, 30 years of research and development, I don't think our companies would know where to start because not only are they researching the drug and going through that development process, but part of the money is spent on running their facilities, keeping the lights on, paying the cafeteria staff, paying their employees. I mean, it's not just that. These are companies. They're running a business in addition to researching and developing drugs.

REPRESENTATIVE TOBASH: So I get it. So at the

end of the day it's what we talked about before. You know, there's transparency and then there's regulation, overregulation that at the end of the day drives up costs.

There was one other just very interesting thing that you indicated, and that was that in three months after you lose your proprietary hold on these medications, you lose 90 percent of your market. I mean, you lose it because it's overpriced. I mean, you have better logos than the generic guys. They would still buy it from you if it wasn't so much more. What does your side of the equation do about the fact that you lose so much business as soon as you no longer have a proprietary grip on the medication?

MS. RYAN: That's why they hope they've got another drug in the pipeline that's going to come to market because some of our companies go out of business. If they don't have something in the pipeline that can recoup for that loss, then they go out of business or they get bought out by another company.

Since I've been at PhRMA, which is almost 13 years, so many of our companies have merged not because they want to have a larger share of the market but because they want to stay in business.

REPRESENTATIVE TOBASH: So you're manufacturers but really you're inventors of these products, and that's

pretty serious --

MS. RYAN: It's all innovation. It's innovation that brings values to the healthcare system in a way that no other entity does.

REPRESENTATIVE TOBASH: Thank you.

MAJORITY CHAIRWOMAN PICKETT: Representative Hal English.

REPRESENTATIVE ENGLISH: Thank you, Madam Chair.

And I'm to your left. Thank you, Ms. Ryan.

For the Committee's sake, I'd like to get the input of Tom Snedden, the Director of PACE Program dealing with rebates and things as it affects our elderly population.

My question, someone raised the issue of can I walk in the pharmacy and ask what's it cost? I'm not sure we really have that right or that ability just like I can't walk into my pizza shop and say, hey, what do you make on a pizza? There's different ways they do it and different discounts and things they have. So I'm not upset by that, but here's my question. We don't have a pizza commissioner but we do have an Insurance Commissioner. So my question is what investigation, regulatory ability, what teeth does the Pennsylvania Insurance Commissioner have to be able to get us answers? Because it seems like we're not able to get them. And I'm new to this Committee so I'm a bit naïve

in the full background. But I'm assuming my Insurance Commissioner can get into the weeds of the whole cycle of all these business entities and to understand it better and to, you know, kind of throw the flag if there's something out of bounds. Am I incorrect? Does the Insurance Commissioner have teeth and to get into finding out information? Maybe it's proprietary but they can, you know, kind of an in camera inspection to know things.

MS. RYAN: Yes. I think that a lot of it is proprietary, and I think that that's true between the manufacturers and the PBMs and the PBMs and insurers. There are a lot of proprietary negotiations that take place. Truthfully, I don't really know what insight the Insurance Commissioner has into all of this. I don't know what goes into rate filings and all of that. That's kind of out of my scope of practice.

REPRESENTATIVE ENGLISH: Okay. I guess I'm struggling with who has the ability to get this information other than someone's pushing on the balloon and it pushes to other entities and we don't get the answer.

MS. RYAN: I do know that there are a lot of bills that are floating around the country right now that would allow a pharmacist to provide information to a patient at the counter that would let them know whether or not they could access the medicine more inexpensively if

they paid cash rather than going through their insurance. So some of that -- I mean, people are trying to figure out what's going on. There are a lot of factors at play. Those are not bills that we engage in, but I know that people are trying to figure out how the system works.

REPRESENTATIVE ENGLISH: Thank you, Ms. Ryan.

Thank you, Madam Chair.

MAJORITY CHAIRWOMAN PICKETT: Thank you.

Chairman DeLuca, you have a question? The last questioner.

DEMOCRATIC CHAIRMAN DELUCA: Yes, thank you.

First of all, thank you for your testimony, Ms. Ryan.

But let me just say to the Member who -- one of our Members who discussed the fact that we don't want to hinder research and development, this bill doesn't -- none of us want to do that. And I stated at the beginning that we understand how research and development has helped the people out there and certainly cut some of the costs. So we understand that. But that doesn't mean that we shouldn't know about what's going on. And if there's anything that you -- I have looked at some of those other bills that you're talking about. They go further than what this bill does. This bill is actually supported by the medical profession, U.S. College of Physicians.

But I just don't understand what is wrong with asking the cost of production that shouldn't be proprietary. I mean, what's proprietary about that? How much money you spend on research and development for a certain drug, we're not asking for proprietary. How much money you spent on advertising for that drug, how much money you spent on research and development for that drug, what's proprietary to that information? I don't understand that.

MS. RYAN: Thank you for your question. Let me just go back for a minute and talk a little bit about the process and how impossible it is for a company to try to put a research and development total cost on a drug because of the process and how nonlinear it is and how hard it is to bring a drug to market when some drugs have, you know, been being researched and developed for 12 years or 15 years or 30 years. It's very hard to go back and put a price tag on that.

DEMOCRATIC CHAIRMAN DELUCA: Don't you take that into consideration when you formulate the cost that you're going to charge for this drug for the time that you have --

MS. RYAN: Yes. So --

DEMOCRATIC CHAIRMAN DELUCA: -- to develop it? I mean, it's part of -- I've been in business. That's where you take that into consideration. How can you come up with

a price, a cost that you're going to charge if you don't have that information?

MS. RYAN: So they look at how much they've spent in research and development generally. They look at the efficacy of the drug. They look at other drugs that are on the market to treat the patient. They look at the size of the patient population. What isn't generally permitted in sort of determining what to price a drug are conversations with insurers on how insurers are going to cover the drug when it comes to market. That's prohibited under Federal law. That's something that PhRMA's working on right now. those conversations would lead in a direction that might be more meaningful if we could figure out how a drug would be covered.

So there are a lot of factors that go into pricing a drug, and it depends on the business model of the particular company, it depends on what else they have in the pipeline. So there are a lot of factors at play.

DEMOCRATIC CHAIRMAN DELUCA: It depends on your advertising budget?

MS. RYAN: The advertising budget -- not all of our manufacturers do advertising. Generics generally don't advertise.

DEMOCRATIC CHAIRMAN DELUCA: Well, I'm not talking about generic but somebody's advertising. I see it

on television all the time they're advertising drugs. Somebody's --

MS. RYAN: But insurers advertise --

DEMOCRATIC CHAIRMAN DELUCA: -- paying for that.

MS. RYAN: -- hospitals advertise. Every part of the healthcare sector advertises.

DEMOCRATIC CHAIRMAN DELUCA: I'm not saying it's wrong. I'd just like to know what's so wrong about asking how much you spend compared to research and development. You spent 20 percent on research and development and maybe 15 percent on advertising when that money can go into research and development and maybe come up with a drug that could cure cancer that we've been waiting for 40 years for the next generation?

MS. RYAN: I don't think --

DEMOCRATIC CHAIRMAN DELUCA: I mean, there's a lot of things we could talk about, but I don't see this stifling research and development. Do you think it stifles research and development, this bill?

MS. RYAN: I was at a hearing similar to this two years ago in Oregon where one of the companies that was sitting at the table wasn't representing Pfizer or Merck or Johnson & Johnson, but it was a small brand company that was working on a particular product. And they said if we were subject to an administrative burden like this, we

would not be able to do business in this State because not all of our companies are big companies. And the big companies probably have more of a burden to do this, but small companies have indicated that they couldn't possibly go through this whole process and fulfill an administrative burden like this.

DEMOCRATIC CHAIRMAN DELUCA: Just one more question. Do your big companies own generic manufacturers, too?

MS. RYAN: Some of them do, yes.

DEMOCRATIC CHAIRMAN DELUCA: Some of them do. Do they reformulate some of the prescriptions and alter it a little bit and then they can extend their patent?

MS. RYAN: A patent life will expire generally at the end of that patent. Do they do things to --

DEMOCRATIC CHAIRMAN DELUCA: A little different --

MS. RYAN: -- extend the patent life? That does happen sometimes.

DEMOCRATIC CHAIRMAN DELUCA: Does happen, okay. That's all. Thank you, Madam Chair.

MAJORITY CHAIRWOMAN PICKETT: Thank you.

Thank you so much for your information, and we will move on.

I apologize for the crunch of the clock that

we're into right now with a lot of great information. And I probably sense some follow-up with all of this. We'll move forward and hope at this point that we can have everybody who intended to testify today be able to do so. Perhaps the Members would only come forth with a question that they feel is so critical to them at this point. Otherwise, they might be willing to put it in writing and we would forward it to the person who testified. Let's just do the best to see if in 30 minutes, but we have to stop at 11:00. It's required when sessions starts.

So our insurance panel is up. If you would kindly each introduce yourself and give us your message today, please.

MR. MARSHALL: Thank you. And in the interest of time, I'll start even before my colleagues have sat down.

Sam Marshall with the Insurance Federation, and I'm joined here by my colleagues from the Blues organizations.

If we could -- and I realize it's been a long hearing, but if we could, just let's step back for a moment. We have a conundrum. There's some truly remarkable, unique, lifesaving drugs out there, and our policyholders understandably want and need them. But they're also remarkably and uniquely expensive, and that's with or without rebates. And our policyholders

understandably want us to get them at the best price possible.

We think the bill is a fair way of doing that by providing disclosure of some key terms that should be considered when we negotiate these prices. And we are involved in the negotiations. We don't just sort of write blank checks and stand on the sidelines. You know, we may do it through PBMs, but we are very involved.

We're always going to be at a loss in these negotiations. Our policyholders need these drugs so we can't walk away from the table. All the bill does is say that when we're at that table, let's have both sides put our cards out. You know, it seems fair to me. You know, I mean, it's much less frankly than we face as we're regulated, you know, by all of you and by the Insurance Department in terms of our pricing and our underwriting practices.

You know, frankly, I heard about how all these disclosures are so radical and innovative. Any drug company is going to have to disclose them to their board, to their investors, to Wall Street, to any -- if you're doing an IPO or anything like that. There's nothing, you know, earth-shattering or secretive or, you know, all of a sudden going to chill any research and development. And that's certainly not the intent, as Chairman DeLuca said,

certainly not something that we as an insurance industry would want.

You know, look, we're open to any ideas that everybody has. I didn't hear in the drug companies' presentation any ideas on how to lower the cost, any ideas on how to hold down the cost. We're open to that. If somebody has a better idea than this, by all means, come to the table. Chairman DeLuca's had this bill out. This is the second session. I think this is, you know, the two-year anniversary of this bill. Other States are considering it.

You know, I'm happy to hear any ideas for having some sort of level of control on high-end drugs that -- and I know monopoly carries a certain pejorative with it. It's what you have when you're on risk. I understand the need, you know, the value of having a patent. It's just saying, okay, while you have that, while you have that absolutely indispensable drugs, let those of us who have to pay for it have some ability to question it. We're going to have to cover it. Patients need it. Give us some tools so that when we go in on behalf of our policyholders, your constituents, and try to hold down the cost so we have a way to do it.

You know, I think this is a fairly benign, you know, form. It's transparency that those of us who have to

pay want. Sometimes you get transparency and the marketplace doesn't use it. It's just information that's out there and collects dust. This is information that we want, we're asking to get. I think an educated marketplace is the best form of regulation you can have, and that's what this bill does.

I'll turn to my colleagues.

MR. BAKER: Madam Chair, Mr. Chairman, I'll go even faster than what I've written. A couple of points we'd like to make are, one, we're not just talking about high-priced new drugs. We're talking about existing drugs that have been around for quite a while, some decades but we're seeing the prices go up substantially. And it does affect our bottom line even though we do use PBMs.

We also have a specialized pharmacy purchaser that deal with the specialized drugs that are usually the more expensive drugs. Sometimes they're cancer, sometimes they're other ones. And they do try to get the best deal possible. For example, with the hep C drugs, Harvoni was selling for $84,000. It was listing that for an 82-day treatment. Did we pay that? No. But did it affect our bottom line? I can assure you, as a small insurance company, it did. So it does have an effect on how much the manufacturer charges to begin with.

Just another couple examples very quickly.

There's a company called Kaleo. They manufacture injectable twin packs of naloxone. And Capital's been very involved in the whole naloxone crisis. We're dealing with opioids right now, and we've given $150,000 in fact to the police forces in our 21 counties to be first responders.

But just one example of this, it was $690 for this product in 2014. This year, it's up to $4,500. So this is not a drug that went down in price or one we were able to negotiate a better price. It actually went up substantially. Lyrica, which you were talking, Mr. Chairman, about what's on television. The ads never seem to stop. Lyrica, which is for, we all know, fibromyalgia, has gone up 51 percent in three years. So, again, it's not like it's at a steady price. Now, of course, we're negotiating through our PBMs and our specialty negotiators, but at the same time, that's what we're seeing, and that's obviously based off the manufacturer's price.

Crestor, another one we see all the time, has gone up 20 percent; Restasis and Zetia have gone up 19 percent, all in a single year. So these are already on an extremely expensive pace and already through our specialized negotiator.

So we're trying to figure out ourselves exactly how the pharmaceutical manufacturers can continue to, we

think, show irresponsible behavior even in the face of the political outrage, which you said we're seeing on the national level and the State level.

MS. KOCKLER: Good morning, Madam Chair, Chairman DeLuca. I'm Kim Kockler with Independence Blue Cross in Philadelphia, and I will be brief as well.

I think one thing we can all agree on, I think we had some great information this morning. I thought the last presentation was very interesting, but I think it was largely a deflection. It's a deflection because this isn't about insurance companies versus pharmaceutical companies. This is about the people in the middle of that that get to the counter and they are paying increasingly large copays and cost-shares.

But there's a reason for that and it starts on the pricing end, the end where we have absolutely no control today. It's not just that they set the price -- and it's really great that there are rebates and yes, we negotiate. We negotiate those prices down. We would be remiss in the face of our customers if we didn't. But when you know that you have to rebate and you set the price and you raise the price whenever you want to raise the price, where is the reasonability there.

So this isn't about what insurance companies do or don't do versus what pharma does or doesn't do. They

perform an unbelievable service. Manufacturing these drugs, as you heard, is complex, sometimes takes years. It's an amazing process. But there are people on the other end of this, people who we are having to charge more money to and have increasingly take their share of the cost up because we are paying for that.

Is there a difference between what the price is when they set it and what we pay? You bet. You know, that's like any of the providers we deal with.

But I'll leave you with, you know, just one example. And as Bob said, you know, in the midst of this opioid crisis, which I know we're all concerned about and we're all trying to do everything we can, we implemented in 2014 new prescribing standards, tighter prescribing standards among our physicians for opioids. So in that 14-month period we saw a reduction of over 40,000 opioid prescriptions, and it was great. It was a 30 percent reduction. Costs didn't go down. Our pharmaceutical cost didn't go down. Even though the prescribing came down, costs went up. In that same period, the cost of one, just one of the abuse-deterrent opioids that we cover went from $600 to $1,600 per prescription in a 14-month period.

So, you know, there has to be some reasonableness here, and I don't think it's unreasonable to require a little bit of transparency. Maybe we need to refine this,

but certainly other States are looking at much more stringent bills than Pennsylvania is. And I also think, as lawmakers in the budget process, you need to be concerned about these prices from a State Government perspective. It's not just corrections. You know, it's PACE, as Representative English mentioned. You know, it's CHIP. It's your State employee benefit program. There are lots of State -- the State's paying a big bill for drugs. I think you need to look into that as well.

So this is something that has a trickle-down effect to lots of folks, so I applaud the Chairman for introducing it and, Chairman, for having the hearing and giving us the opportunity. We're happy to answer any questions following.

MR. YANTIS: Good morning. Michael Yantis, Vice President of State Government Affairs for Highmark Inc. We're the insurance arm of Highmark Health, which is an integrated delivery and financing system. We have a provider side. So we come at this with a unique perspective because we're continuing to look at this from the global perspective. I will keep this brief.

Part of the reason why we're here having this discussion is because you, your colleagues, the Commissioner, and most importantly -- and not to diminish your input -- our customers are demanding that we figure

out ways to bend the cost curve in health care. So this discussion is taking us down the path of looking at what is driving those costs.

I'd like to start with Representative English's analogy about the balloon, and this, I hope, will address some of the questions that folks had asked in terms of cost-sharing and what customers pay and what the Insurance Department knows.

Think of the total cost of your health care as that balloon. Let's use the individual market. That's the balloon. We can slice that balloon any number of ways, which includes the premium and the cost-sharing, the cost-sharing, which falls into the three bucks: deductible, coinsurance, and copayment. We could produce a policy, we could write a policy that has zero cost-sharing, 100 percent premium. It's going to be very, very expensive because that raw cost is the same. As we begin to parse that out, you begin to find a balance between the premium and the cost-sharing. Our customers demand those options. Our customers ask us to write those options.

In the individual market, we're actually mandated to structure those policies a certain way. You've heard the platinum, gold, silver, bronze analogies. What that means at the end of the day, a platinum policy has to be 90 percent premium, 10 percent cost-sharing, all the way down

to bronze, which is 60/40. Those plans are all priced accordingly.

When we file those products with the Insurance Commissioner, those products are priced according to the 90/10 all the way down to the 60/40 split. So when they review the policies, the price for that bronze policy reflects a 60 percent amount that the insurance company would pay out to cover the cost of health care. The customer is responsible for the 40 percent.

So the answer is yes, the cost-sharing is factored in when those policies are reviewed and evaluated and approved by the Insurance Commissioner, as well as the Federal Government.

There's also a backend check on us as well. We are required to file annually with the Federal Government what is called a medical loss ratio report. We are mandated by Federal law that 80 to 85 cents of every premium dollar that we receive from a customer goes out in medical care. So we can answer that question. We can tell you exactly how much of every dollar a customer pays goes out in medical care. Now, keep in mind, the 80 and 85 percent is the mandated minimum. Last year for Highmark in the individual market our MLR was $1.19. We were paying out $1.19 in healthcare cost for every dollar that we took in. We can tell you that because we're required to file

that.

So that's just to shed some light and provide some context to this discussion in terms of the cost of health care and why we're trying to find a balance, and at the end of the day, I think the word we're all looking for is sustainability. How do we make the healthcare market sustainable for the folks that are paying the costs? Thank you.

MAJORITY CHAIRWOMAN PICKETT: Thank you so much.

Representative Evankovich, can you make it a 30-second question with a 30-second answer?

REPRESENTATIVE EVANKOVICH: Very, very fast, Madam Chair.

I heard over and over again from these testifiers that they negotiated with their PBMs, they're working. Nobody up here, I don't think anyone is questioning whether or not insurance is being squeezed and that something needs to happen with the overall rising costs of health care.

But I just want to throw out a few numbers and get your response. If you take the four biggest drug companies in the United States -- GSK, Pfizer, Merck, and Eli Lilly, respective revenues of $24 billion, $49 billion, $40 billion, and $20 billion -- that's $133 billion in 2015. If you look at the three biggest PBMs, CVS Caremark, revenues of $153 billion; Express Scripts, revenues of $104

billion; Optimum Rx, revenues of $48 billion, that's $405 billion in revenue in 2015 from the top three. The top four largest drug manufacturers in the United States had revenues of $133 billion.

And we're not even talking about -- if anyone has a dispute with this chart that was put forward, please share it. But we're not even talking about the wholesaler. AmerisourceBergen, a company headquartered in southeastern Pennsylvania, had revenues alone of $135 billion in 2015. Why are we talking about the manufacturers' price? Why are we not talking about all of the other bites of the apple? That pharmaceutical passes this way to the patient and it's the patient's money that flows back this way.

Was that fast enough, Madam Chair? It's not right at 30 seconds, but I did my best.

MR. YANTIS: Just a quick reaction to that because I think it's a great point to raise, and I think at the end of the day all of us at the table would agree. All those players need to be at the table. We're talking about what is driving healthcare costs and the best way to manage it.

This particular approach that the legislation is seeking to is focusing on one particular area because it is a high-cost area. In the written testimony, Highmark, we provided statistics somewhere in the range of 20 percent

increase in our pharmacy spend, 50 percent increase in specialty drug spend trend, so that's why the focus is there because those numbers are significant that are customers are faced with, but no one's going to dispute that all those players need to be at the table because we're talking about the healthcare industry as a whole.

MR. MARSHALL: The other thing, Representative Evankovich, as I think Commissioner Miller stated at the outset, there is no one silver bullet. This is a part. But what I haven't heard, you know, from the pharma crowd is any other ideas. And if you have other ideas, put it in writing. You know, I mean, it's great to come up and say, hey, we're not the only part of the apple. True.

And, you know, there may be multiple bills, but at some point somebody has to say this bill doesn't work or this bill is flawed or this bill is bad or something like that because what we haven't heard is why this bill is bad. There's no intent to get into proprietary information. Frankly, that's something that one drug company would want against the other drug company. They're the ones who compete.

You know, if this bill is bad, if this bill somehow slows up research and development, if this bill is asking for information that's far too cumbersome for GlaxoSmithKline or Pfizer or Merck to provide, I'd be

astounded, but let's hear what the problem is.

I understand somebody doesn't want to do it. I mean, we don't like our rates being regulated by the Commissioner. We accept that. That's the price of being in this business. What we're asking is that, you know what, it's the price of drug companies to be in this business to sell drugs to your constituents, our policyholders. Let's have them give some level of basic disclosure on what their underlying costs are so when we're at the negotiating table, we have some tool. It may be us through PBMs. There may be other measures. But if somebody has other measures, let's see them.

What I haven't heard is why this bill is flawed, and I think that should be the focus of this group.

MAJORITY CHAIRWOMAN PICKETT: Thank you. That gives us some edge for follow-up.

And I'm going to move on now to -- I thank this panel so much. I know I'm cutting you a little bit short and I apologize very much for that. We're going to hear from AARP at this point, Ray Landis, who is an Advocacy Manager. And, Ray, perhaps you could summarize your message to us today. If you could hit the five-minute mark, you'd do us a lot of help here.

MR. LANDIS: I promise I will hit the five-minute mark and try to be even briefer.

Again, I'm Ray Landis. I'm the Advocacy Manager for AARP Pennsylvania. We have 1.8 million members in Pennsylvania. And I think the key point in looking at this from the older Pennsylvanians' perspective is that the average older Pennsylvanian takes 4.5 prescriptions drugs every day. They have 4.5 prescriptions. And that adds up very rapidly as we see the increasing cost of prescription drugs.

AARP put out a national report just in December that showed that the average retail price increase for a market basket of prescription drugs was 15.5 percent last year. And remember that the overall inflation rate last year was 0.1 percent, so we're talking about an increase dramatically above the inflation rate, and it's not the first year that this has happened. You know, we heard this spike in 2014. Well, four years in a row we've seen double-digit increases in the retail price of prescription drugs.

You know, and we've heard testimony this morning about, you know, the retail price doesn't reflect the rebates and it's no wonder consumers get frustrated. You know, we represent the consumers at the end of this, and they don't understand rebates and the negotiations and PBMs and everything that goes into what the end price that they pay at the pharmaceutical counter. They just know that, if

they have insurance, their copays are going up, their deductibles are going up, and they're getting squeezed by increasing pharmaceutical costs.

You know, it's not only AARP that's pointing this out. The University of British Columbia did a study that was reported on by UPI just a couple days ago that show that 16.8 percent of seniors in the United States have not filled a prescription in the last year because of the cost. You know, we heard that prescription drugs do so much for health care and bring overall healthcare costs down, but if people can't afford to fill their prescriptions, it's not working.

And I think the final point that I want to make is that this isn't a problem that's going to go away. And I noted in my testimony that the Aging and Older Adult Service Committee is holding a hearing this morning at the same time this hearing is going on that's talking about the demographic changes that are coming to Pennsylvania. And if we're looking at a situation where older Pennsylvanians are taking 4.5 prescription drugs per person and the impact that that has on our PACE and PACENET Program, on Medicaid, on all the other programs, the demographic changes that are going to take place in this State over the next few years where we're going to see the older population, the 65-plus population go from 17 percent -- approximately 17 percent

of our population right now to over 22 percent of our population by the year 2025, think about what that's going to do to our State programs that provide prescription drug assistance, whether it's PACE and PACENET for older Pennsylvanians but also the increasing number of older Pennsylvanians that are on Medicaid because they've exhausted their assets and need health care from that system.

It's a problem that's only going to grow, and we've got to think about from the prescription drug perspective how we're going to address that.

And I'd echo Representative English's comments about how PACE and PACENET have looked at controlling the costs of prescription drugs, and certainly in the purchasing that's gone on within the Department of Aging, they've come up with some innovative ways to control prescription drug costs, and I would urge this Committee to take a look at what PACE and PACENET have done in controlling the costs as a way to maybe look at how that can be broadened to a broader group of Pennsylvania.

And, you know, the bottom line is that we do think House Bill 161 is a big step forward on transparency and, you know, to reflect what's gone on in this hearing before now, maybe it shouldn't stop with just looking at the pharmaceutical manufacturers. Let's have transparency

for this whole system so we know what is going on and contributing to the rising cost of prescription drugs because in the end for consumers it doesn't really matter whether it's the pharmaceutical manufacturers that are making such a dramatic profit and contributing to the increase in cost or the insurers or the pharmacists or the PBMs. Consumers just know that they can't afford the cost increases that they're seeing right now, and I'd urge the General Assembly and this Committee in particular to consider that as we move forward.

So with that, I'm glad to answer any questions.

MAJORITY CHAIRWOMAN PICKETT: Thank you, Mr. Landis.

In all fairness, I'm going to move forward to the next panel now, but I do thank you for your time and your information, and we will certainly be considering it further. Thank you so much.

The pharmacy panel, Patricia Epple, the CEO of the Pennsylvania Pharmacists Association; and P.J. Ortmann, who is a pharmacist.

MS. EPPLE: Good morning. And I'll be real brief.

MAJORITY CHAIRWOMAN PICKETT: Just save a little bit of time for Mr. Phillips and we'll be okay.

MS. EPPLE: Okay. All right. So we've had some

good comments this morning, and I just wanted to highlight a couple of them because they're ones that we truly believe are important. And that is it is a complex system.

We also have a model in our packet of how complex this is, and I would reference that because I think we heard several questions around it and it certainly drives that home.

We're also very interested in transparency across the whole system. I would argue that the community pharmacy in our pricing is probably as transparent as anything. And certainly we've advocated for PBMs in the past to be transparent. Last year, in fact, you passed a bill which did at least require them to register with the Insurance Department. That has not been implemented as yet. I think that is just the beginning.

I'd also suggest that last year we also put a pricing system into place with the PACE Program, which went to the NADAC system, which is a much more transparent pricing mechanism than the AWP and other stuff you heard this morning, and it paid a fair dispensing fee for pharmacies. So that was truly just laying out exactly what those costs are.

But we were specifically asked to come and talk to you about manufacturer coupons. It's just one in a long list of kind of gimmicks. You heard about rebates already

this morning. Coupons are typically, you know, what a brand drug company gives to a patient that makes them believe that they're getting a good deal. Coupons always sound really reasonable. The problem with coupons is that they are on branded medications. They only last for a certain amount of time. They don't incorporate in what the insurer is going to pay for the drug anyway. So there's a lot of things behind that, and our testimony goes into that in a little bit more detail. And P.J.'s going to give you some specific examples on that.

So, P.J., can I turn it over to you?

MR. ORTMANN: Good morning, everyone.

I'd like to address the one example that was given earlier by the Representative on the $2,000 prescription. This is a sample of the card that's given to the doctor, and as she was kind to state, it only cost the patient zero. With those two medications that any of us could go to Sheetz or Turkey Hill and buy over-the-counter, my question is how did the PBM allow that prescription to go through? It doesn't matter if that drug's too expensive and you're paying for it with a high deductible. You would never take it. Why was the PBM allowing that to go through? Which means ultimately that plan, which I assume is part of what you belong to, is paying that $2,000.

I have an independent consulting company and

currently follow a county government $4,000 claim for a lidocaine jelly that I went on eBay and found without a prescription for $35. But the county government paid $4,000 for that prescription because the PBM allowed it to go through.

I can't stress enough, everything we're looking at today, again, as Pat mentioned and several previous speakers, this is a huge problem, but the PBM industry controls what gets on those formularies, whether it's the health plan or for insurer. It's a pay-to-play game. These rebates have to be included in that. The transparency needs to include that middle processor because as the pharmacist at the end of the line and I have to explain to the patient with a $6,000 deductible this is $320 until you meet your deductible, then it'll drop down to $100, do you want to use up your deductible or do you want me to just do this as a cash prescription for you to save you money? It's a real conundrum for them because if it's November, there's no question. They're not going to get to it. But in January are they going to use their $6,000 deductible or do they take the lower price right now.

And one last thing, this is a claim dated the 6th of February, two days ago, for Celebrex, the brand Celebrex. The patient had a zero copay but the cost was

$327. Generically, had I filled this with a generic, it would have been about $20. This goes on every day. And the examples that we have at the back of your packet are for branded drugs. I'm looking at Celebrex here, $4 copay. Well, my company has a $10 generic copay. It's cheaper for me to get the brand. Hey, Doc, write for the brand prescription. I don't care that my employer has to pick up that $300 bill.

This is a much broader program. It goes well beyond the cost of the medications. It's what happens along the way. And as we go down to that one graph that showed the patient and the pharmacist, I live that every day and these are the discussions we have on a daily basis.

Thank you. I'd be happy to answer any questions.

MAJORITY CHAIRWOMAN PICKETT: Thank you so much. And I appreciate that offer. I'm going to, however, move to let Mr. Phillips be sure that he gets his testimony in today. And again, I sense follow-up.

Go for it, Vince.

MR. PHILLIPS: Good morning, all. This may be the quickest two-minute testimony I've ever given but hey -- all right. Here's every person's story this year. My wife's personal individual policy premium increased by 68 percent. Now, she had choices. She could go with the 45 percent increase with a much higher deductible, much higher

copay. That's the world we live in.

What your panel is doing today and what Chairman DeLuca is doing with House Bill 161 has several takeaways to it. Number one, the premium is the symptom; it's not the cause. And I think that's important to remember. Now, my wife says the premium. Of course, I pay the premium so I have somewhat of an interest in that as well. But you understand that the premium is the symptom.

Number two, transparency is a tool. It's a device. It's a way to help consumers be better educated, to help them have more information so that hopefully they can make an educated choice. Rather than paying that $2,008 prescription Representative Quinn mentioned, obviously something cheaper might be found if there's enough transparency. Of course, consumer education goes with that.

I remember I was in the pharmacy and there were two lovely ladies talking about the high cost of prescription drugs. They were both on the PACE or PACENET Program, and one of them said $9 for this prescription is absolutely outrageous because they didn't have a clue as to what the cost dynamic is. So consumer education has to be a huge part of it.

But here's the thing -- and mapping backwards from the price someone pays at the drugstore I think is

critical in the larger picture. But this is a very important first step, and that's why I applaud the Committee for taking up this bill because I think it is that important. You've got to venture forth. You've got to take a step. Where that path leads I don't know either, but I know that you have to start and this is a good place to do so.

Last observation, workability. One thing I've not heard is if this legislation were enacted, how would it work? And the answer is the Insurance Department will figure it out. However, the Insurance Department, even though it's insulated from the appropriations and State budget process because of the dedicated insurance regulation and oversight fund that the General Assembly enacted several years ago, well, I don't know the actual figures as of yesterday's presentation by the Governor, but I do know that there's probably about $38 to $40 million in the fund, and I know that the Department gets $25 to $27 million of that fund, which means there's a residual. There's about, whatever, $15, $20 million left in the fund that's not being utilized. Give the Department the tools it needs to actually implement this thing.

Now, I know that's a different Committee, I know that's the budget cycle, et cetera, but unless you give the Department the tools that it needs, this will be a great

idea without the follow-through that I think is absolutely needed.

Number two, workability takeaway is the Department has really gone to great lengths to try to make things more visible. For example, you go on the Department's website, you'll see what the ACA cost -- I'm sorry, rate filings are about. And they've done videos and tried to educate people as to how health insurance works, but frankly, there's more that has to be done.

In preparation for this testimony, I played a game called "Let's explore the Insurance Department website." I said I'm going to find out what the rate filing is by one company. And so I went to the home page and I had consumer, companies, coverage as three options to look at. Let's try coverage. There were nine headings under coverage. Okay. Health looks promising; let's try that. And I found in the health tab there were lots of excellent resources on how health insurance works but no rate information.

Okay. Let's go to consumer. There were 10 headings there and there were topics there like how to choose a company, more education; how to find an insurance professional. I kind of liked that provision, that component. And there was one on Affordable Care Act rate filings. Okay. So far so good. But what if it is not an

ACA rate filing? Then what do I do?

Okay. I'll go to companies. So I went to companies, and then I go through product and rate information, and then I go to submission checklist and product requirements, and then I go to accident and health where I'm presented with a menu of the companies that might want to look at. In other words, part of the challenge is going to be for the Insurance Department to take this information -- and it will be a lot of information -- and make it accessible.

So I maintain to you that transparency without accessibility and without giving the Department the working tools it needs to implement this will result in a wonderful goal that is not effectuated as well as it ought to be.

And I thank you very much and --

MAJORITY CHAIRWOMAN PICKETT: Thank you.

MR. PHILLIPS: -- oh, I'm four minutes late. Sorry.

MAJORITY CHAIRWOMAN PICKETT: Thank you. And we will adjourn because we are required to be in session now, but thanks to everyone for the incredible information and time they gave us today, and we will go from there. Thank you.

(The hearing concluded at 11:03 a.m.)

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